Amherst Pediatrics, LLP
31A Hall Drive
Suite 2
Amherst, MA 01002
413.253.3773 ph
413.256.0215 fax

Please complete this form for Motor Vehicle Accident Visit

Patient Name ______________________________

Parent Name ______________________________

Address ______________________________

City________________ State________ Zip__________

Home Phone____________________ Parent Work Phone________________

Automobile Insurance Co. ______________________________

Insurance Carrier's Address______________________________

City________________ **State**________ **Zip**__________

Policy Holder's Name ______________________________

Policy and/or Claim Number ______________________________

Agent's Name ____________________ **Agent's phone #**________________

Date of Accident ____________________

I authorize Amherst Pediatrics to release medical reports related to my illness or condition to the Automobile Insurance Company. I authorize payment of medical benefits to Amherst Pediatrics. In the event that the Automobile Insurance Company denies the claim for injury, reimburses me for the claims submitted for the injury, or makes a monetary settlement, I hereby agree to pay Amherst Pediatrics the usual and customary fees for services rendered.

______________________________ ____________________

Signature Date

____

Please print name here

***BOLD printed areas are mandatory to file a claim**