



Patient : \_\_\_\_\_ DOB: \_\_\_\_\_

You have indicated to us that we are billing workers compensation, auto insurance or your personal injury insurance. We need all of the following to bill on your behalf. Please verify that you have provided our office with this information. If we do not have the correct information, this is a reminder that you will be held responsible for the total amount of the charges.

- Claim Number
- Date and State of Injury
- Billing contact, including name & telephone number
- Billing Address
- Requirements for Pre Authorization

If you have any questions, please contact our office at (603) 627-6381.

I have read the above statement and understand my financial responsibilities.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date