WOODCREEK HEALTHCARE

INFORMED CONSENT
AGREEMENT TO BILL PERSONAL INJURY PROTECTION (PIP) INSURANCE FOR MOTOR VEHICLE ACCIDENT (MVA) VISITS

(Please Print)

Today's Date ____________________

PATIENT INFORMATION

Patient Name ________________________________ Date of Birth ____________________
Last First MI mm/dd/yyyy

PIP INSURANCE INFORMATION

PIP Insurance ________________________________ PIP Insurance Phone # ____________________

PIP Insurance Address ________________________________

Policy Holder's Name ________________________________
Last First MI

Policy # ________________________________ Date of Accident ____________________

Patient's relationship to policy holder ❑ Self ❑ Spouse ❑ Child ❑ Other

AGREEMENT

☑ I understand that Woodcreek Healthcare does not bill health insurance for MVA visits.

☑ I authorize Woodcreek Healthcare to bill my PIP insurance for visits related to this accident.

☑ I understand that ultimately I am financially responsible for my account at Woodcreek Healthcare and that after 30 days from date of visit, if my PIP insurance has not paid the balance, Woodcreek Healthcare may bill me directly for the remainder.

☑ I understand this form and all my questions were answered to my satisfaction.

Signature ________________________________ Date ____________________

Printed Name ________________________________ Relationship to Patient ____________________