PLEASE MARK (X) AS MANY OF THE FOLLOWING STATEMENTS THAT APPLY TO YOUR CASE.

⌋ I have Medical Payment (Med-Pay) benefits, either, personally or through the driver of my vehicle.
⌋ I have group health insurance benefits either directly or through my spouse or parents.
⌋ I have retained an attorney,
⌋ I have not retained an attorney.
⌋ I have the adverse or third party information available. (Insurance company of the other driver.)

PLEASE PROVIDE THE APPROPRIATE INSURANCE INFORMATION:

1) YOUR AUTOMOBILE INSURANCE CARRIER: _____

Address:_____Insured: _____

Claim #:_____Policy: _____

Telephone:_____Fax: _____

2) YOUR GROUP HEALTH INSURANCE COMPANY: _____

Address:_____Insured: _____

Date of Birth:_____Policy:_____SS #: _____

Telephone:_____Fax: _____

3) ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER: _____

Address:_____Insured: _____

Claim #:_____Policy: _____

Telephone:_____Fax:_____Claim Rep: _____

4) ATTORNEY:_____ Legal Assistant: _____

Address: _____

Telephone:_____Fax: _____

HIPAA COMPLIANCE
Deer Valley Chiropractic is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature:_____Date: _____

Witness:_____Date: _____