

Patient name \_\_\_\_\_ Today's Date \_\_\_\_\_

**Accident Information**

Date of Accident: \_\_\_\_\_ Type of Accident: \_\_\_ Auto \_\_\_ Other

Please describe accident (if not auto) \_\_\_\_\_

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*Non-auto Accident Insurance Information*

Name of Business or Property Owner: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Address: \_\_\_\_\_

Are you or a family member going to file a liability claim in connection with this injury? Yes \_\_\_ No \_\_\_

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*Complete this section if an auto, premises medical, or liability claim will be filed*

Name of policy holder \_\_\_\_\_ Claim Number \_\_\_\_\_

Address of policy holder \_\_\_\_\_

Name of Insurance Company \_\_\_\_\_

Address of Insurance Company \_\_\_\_\_

Name of Patient's Legal Representative (if any) \_\_\_\_\_

Phone number of legal representative \_\_\_\_\_

**INSURANCE AUTHORIZATION AND ASSIGNMENT**

I authorize payment of auto, premises medical or liability insurance benefits directly to FEIGENBAUM NEUROSURGERY, P.A. I consent to the release of information to the insurance company and to my referring physician.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

**LIABILITY LIEN AUTHORIZATION**

I grant Feigenbaum Neurosurgery, P.A., a lien on any and all claims, counterclaims, demands, suits, or rights of action for damages I may have, assert, or maintain against any third party who may have caused injuries for which Feigenbaum Neurosurgery, P. A., provided medical and health care services, for the cost of such services.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date