Newcomb Chiropractic Clinic
400 N. Main Ste 1
Broken Arrow, OK 74012
(918) 251-4239
Fax: (918) 258-7200

Name: _____ Accident Date: _____

Accident occurred in what state: _____

Please Choose from one of the following payment options:

Option 1: Is this your option? ☐ Yes ☐ No

If **YOUR** auto coverage includes MED PAY, we suggest you contact your insurance agent about filing a claim for MEDICAL EXPENSES. It **does not matter** who was at fault in the accident. You pay for this coverage and are entitled to use it no matter which party is at fault. Filing a MED PAY claim, according to state law, **CANNOT** raise your insurance premium or count against you in any way.

Insurance Company _____
Agent's Name _____
Agent's Phone Number _____
Adjuster's Name _____
Adjuster's Phone Number _____
Claim Number _____

Assignment of Benefits

I hereby authorize payments of benefits to Newcomb Chiropractic Clinic Inc, PC for medical services provided.

Date: _____ Signature: _____
Patient or Patient's Guardian if Patient is a minor

Option 2: Is this your option? ☐ Yes ☐ No

You may pay your expenses as you go with cash, check, or credit card. We will provide insurance information per your request.

Option 3: Is this your option? ☐ Yes ☐ No

If another party is at fault you may want to pay your bill from your settlement with the liability insurance. If this is your only option, we will file a Physician's Lien against the claim. This will notify the insurance company of our interest in the claim or add our name to any settlement. **Ultimately, you are responsible for all expenses related to your care**.

Third party's Name _____
Insurance Company Name _____
Insurance Company Address _____
_____
Insurance Company Phone Number _____
Claim Number _____
Adjuster's Name _____

Signature: _____ Date: _____