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 _____