Chestnut Hill Chiropractic & Rehabilitation
617-332-5105 info@chestnuthill-chiropractic.com
60 Kendrick St. Needham, MA 02494

PERSONAL INJURY CLAIMS POLICY:

Chestnut Hill Chiropractic & Rehabilitation (CHC) is set up to process billing for personal injury claims. These claims are assigned to Dr. Gensler, which means that we bill the auto insurance company(s) directly to receive payment. In cases with settlements, an attorney will issue payment when a settlement has been made.

YOU ARE REQUIRED TO:

1) Report your accident by completing an accident report and a Personal Injury Protection (PIP) form. This form establishes your claim. If this not returned to your insurance company in a timely manner it may hold up payment of your claim.
2) If an attorney is involved. You must give CHC the contact information for your attorney.
3) Complete all information on each form provided to you by CHC.
4) Sign the Bottom of this form agreeing to our policy and non – payment clause.

If we do not have the necessary information to facilitate your claim by the third visit to our office, you will be required to pay us directly for the services rendered until the forms are complete. We can not begin your claim submission without all the information requested. We may ask for your assistance to get a status report or secure a payment.

AGREEMENT TO PAY MEDICAL COSTS IN THE EVENT OF NON-PAYMENT FROM PERSONAL INJURY MEDICAL CLAIM

In the event that my insurance claim is denied and / or payment is not received for services rendered as a result of my personal injury medical claim, I, _____ hereby agree to pay Dr. Robert Gensler and/ or (practice) Chestnut Hill Chiropractic & Rehabilitation the balance due for any / all services rendered.

Date: _____ Signature: _____

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Personal Auto Injury Information

***YOU MUST CONATCT YOUR INSURANCE COMPANY TO REPORT THE ACCIDENT, GET A CLAIM NUMBER, COMPLETE A PIP FORM, AND CONFIRM YOUR BENEFITS!**

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Please complete this form if you were involved in an automobile accident and are filing a claim for chiropractic services related to your injuries.

_____ _____
(Your Name) **(Date of accident)**

_____
(YOUR automobile insurance companies name)

_____ _____
(Policy #) **(Claim #)**

_____ _____
(Name of Agent or Adjuster) **(Adjusters / Agents phone #)**

_____
(Mailing address to send claims to your insurance company)

Did you receive a PIP form from your insurance company to complete and return to them? **YES** ☐ **NO** ☐

Please provide us a copy of the completed PIP form to assist us in processing your claim.

Is Med Pay available for your claim? **YES** ☐ **NO** ☐ Amount available $_____

Is there a deductible to meet? **YES** ☐ **NO** ☐

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Personal Injury Questionnaire

In your own words please describe the accident below:

_____
_____
_____
_____
_____

Were you the driver or a passenger in an auto? _____

Please describe your injuries / symptoms: _____
_____
_____

Did you have any physical complaints **BEFORE** the accident? ☐ YES ☐ NO
Describe: _____

Did you miss work due this accident? ☐ YES ☐ NO Dates? _____ - _____

Your Signature: _____ Today's Date: _____

HEALTH BENEFIT AFFIDAVIT

In accordance with Chapter 273 of the Act of 1988, we are now required to obtain information regarding other health benefits (HMO, Medicare, health insurance, etc.) available to you before we can process your claims for Personal Injury Protection Benefits, (P.I.P.).

Any medical expense in excess of $2000.00 will not be paid under P.I.P. if those expenses will be compensated, paid or indemnified by an outside insurance carrier, (HMO, Medicare, health insurance, etc.). Bills submitted for over the $2000.00 limit, must be accompanied by a statement from your health insurance carrier as to their reason for non-payment.

If you have other benefits available to you, please complete and sign the appropriate section(s) below. SECTION ONE: If you are the policyholder with other benefits (health insurance). SECTION TWO: If you have other benefits through another policyholder such as, a spouse, parent, or legal guardian. SECTION THREE: If you DO NOT have any other benefits (health insurance) .

Complete one Section only

Section One: Benefit Information **(Health Insurance)**

Your Name _____

Health Insurance Carrier: _____

Policy Number: _____

Date: _____ Signature: _____

Section Two: Additional Benefit Information

Your Name _____

Health Insurance Carrier: _____

Policy Number: _____

Name of Policyholder: _____

Relationship: _____

Date: _____ Signature: _____

Section Three:

I certify that I do not have any accident and /or health benefits available to me through my own policy or that of a household member which covers chiropractic care.

Date: _____ Signature: _____

REV 3/22/04