LAKE SERENE CLINIC
PRIMARY CARE & WALK-IN

Date: _____/_____/_____

Patient Name: _____

Mailing Address: _____

_____

_____

Insurance Company: _____

Billing Address: _____

_____

_____

Claim Number: _____

Telephone Number: (_____)_____-_____

Adjuster's Name: _____

Date of Incident: _____/_____/_____

PAYMENT AUTHORIZATION:

_____ I authorize payment directly to the Lake Serene Clinic for Medical Services rendered pertaining
(pt. initials) to the automobile accident detailed above.

MEDICAL RELEASE AUTHORIZATION:

_____ I authorize any insurance company, organization, employer, hospital or health care provider to
(pt. initials) release any necessary medical information requested.

I understand it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

_____

Patient Signature