Rehabilitation Options of Issaquah Auto Questionnaire

Date: _____/_____/_____
Patient Name: _____
Patient Address: _____
City: _____ State: _____ Zip: _____
Patient Phone: _____ Other Phone: _____
Patient SSN: _____ Sex: _____ Date of Birth: _____
Spouse's Name: _____ Date of Birth: _____
Spouse's SSN: _____
Date of Auto Accident: _____
Place of Auto Accident: _____
City: _____ Sate: Zip: _____
Did you report the accident to your insurance company:_____

Who is the registered owner of the vehicle?_____

Do they have PIP on their insurance policy?_____

Who was driving the vehicle at time of accident?_____

Do they have PIP on their insurance policy?_____

Please explain in detail how your accident happened: _____
_____
_____
Your Insurance Co Name: _____
Insurance Co Address: _____
City: _____ State: _____ Zip: _____
Insurance Co Phone: _____ Ext: _____
Policy#: _____ Claim#: _____
Name of Your Insurance Adjustor: _____

Your Attorney's Name (If applicable): _____
Attorney's Phone: _____ Ext:_____
Sign below to give permission for ROI to contact attorney above:
X_____

Often times PIP coverage will exhaust during treatment. If we are contracted with your private health insurance we will bill them for your services. If you do not have regular health insurance we require a $500 deposit be made. This will be reimbursed to you upon completion of care and payment of all medical services rendered. We offer a cash discount for uninsured patients. We require full payment at the time of each appointment.