



## Auto / Personal Injury Protection (PIP) Accident Policy

76A Front Street, Suite 21, Scituate, Massachusetts 02066

(781) 545-7388 • (781) 545-6552 fax

In those states with no-fault insurance, persons involved in an auto accident are entitled to 100% coverage for care and wages lost under what is known as PIP insurance. The maximum benefit for an auto accident is generally \$2,000, per person. More benefits may be available under the medical payment portion of your insurance. Your auto insurance cover sheet should state the amount of coverage available in this regard.

In order for this office to begin filing claims for services rendered you must complete the following steps:

1. Complete an Automotive Accident Report and file a copy with the police and your automobile insurance carrier (regardless of who is at fault).
2. Provide this office with all pertinent information relating to the accident.
3. Sign the attached form and include the Assignment of Benefits form. If you are or will be represented by legal counsel, you and your lawyer must also complete the form.

We will bill the insurance company and payment will be received directly from them. It is important to understand that insurance policies are an agreement between you and the insurance carrier. You are personally responsible for all charges incurred in this office.

We expect payment in full when these services are rendered until all necessary information has been received and coverage has been verified. Any payment for services that the insurance company denies or refuses to cover will become your responsibility.

If there is no payment from the insurance company within 60 days, payment must be made in full for any outstanding balance, and payment will be made for each service as they are rendered. If care is terminated for any reason, payment must be received in full for any outstanding balances.

*I have read and understand this policy.*

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Member Name (please print)

Member Signature

Date

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Witness Name (please print)

Witness Signature

PROMOTING  
HEALTH AND  
WELL BEING  
THROUGH  
CHIROPRACTIC  
CARE



# Irrevocable Assignment of Benefits

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To (Insurance Carrier) \_\_\_\_\_  
Carrier Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

*In consideration of receiving chiropractic services from Dr. \_\_\_\_\_  
having its usual place of business at \_\_\_\_\_  
I hereby assign and transfer to \_\_\_\_\_, D.C., benefits  
due me under my personal injury protection benefits and/or medical payment coverage of my  
automobile policy coverage for services rendered to me.*

*And I hereby request and direct that the above-named insurance carrier pay to  
Dr. \_\_\_\_\_, such sums as may be due Dr. \_\_\_\_\_  
upon receipt by the above-named insurance company of an itemized statement for chiropractic  
services rendered to me by said doctor.*

*It is further understood and agreed that payment of said itemized statement by the above-named  
insurance carrier as herein directed by me shall be considered the same as if paid by the above-  
named insurance company directly to me.*

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Member Name (please print) \_\_\_\_\_ Member Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature (if insured is a minor under age 18) \_\_\_\_\_ Date \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Carrier Policy # \_\_\_\_\_ Date of Injury \_\_\_\_\_

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