Brevard Orthopaedic Spine and Pain Clinic, Inc.
THE B.A.C.K. CENTER

Pt. Name: _____ Pt. DOB: _____

Auto Information

Date of Accident: _____/_____/_____

Name of Auto Insurance: _____

Auto Policy ID #: _____

Auto Claim #: _____

I clearly understand and agree that all services rendered to me are charged directly to me and I am personally responsible for payment in the event that my claims for my Auto Benefits are denied. I understand that filing for Auto benefits does not relieve me from my responsibility for the payment of all charges.

*******Please bring your auto insurance card with you to your first visit*******

_____ _____

Printed Name Signature Patient/Guarantor Date