MVA/PERSONAL INJURY
Third Party Billing Information

MVA ____ Other injury _____

Patient-complete this section

1. Patient Name. _____D.O.B_____
2. Home Address:_____
3. City.. _____State.._____Zip.._____
4. Date of Injury _____ State in which injury occurred:_____

Insurance Information.

Fax: _____

Phone :_____ Contact. :_____

Claim/case number. :_____

Bill to:

_____

_____

_____

Description of Injury:
body part affected: _____
_____
_____
_____

_____ _____

Patient Signature Today's Date

(this form is in addition to and does not take the place of the patient registration form)

Created 6/16/2016 updated 6/20/2016, 7/25/2016, 9/01/2017, 02/18/2017

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Consent for Treatment, Billing and Release of Protected Health Information

I understand that by my signature below:

- I authorize the release of my medical information necessary for the application of insurance coverage and/or the process of claims for the services rendered by Rural Health, Inc.
- I authorize payment of such services rendered to be made directly to rural Health, Inc.
- I am responsible for any amount not covered by insurance.
- I am confirming that I have received a copy of Rural Health, Inc's "Notice of Privacy Practices" and "No Show Policy" at my initial visit and, if requested, at subsequent visits.
- I voluntarily consent to treatment, tests, medication, nursing services and other care rendered by my provider or other Rural Health, Inc. personnel under the authorization of my provider.
- I have the right to ask questions and receive information about my care and treatment.
- I have the right to withdraw my consent for treatment or tests.
- I consent to blood tests (including those for communicable diseases) when Rural Health, Inc. personnel have been exposed to my blood/bodily fluids.

Patient (or Parent or Guardian if patient is a minor)

Signed_____**Date:**_____