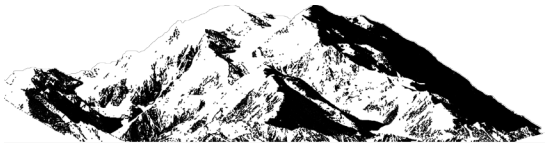


McKinley
Orthopedic & Sports Medicine

AUTO POLICY INFORMATION

PATINET NAME: _____

DOB: _____ PHONE #: _____

INFORMATION REQUIRED TO BILL AUTO INSURANCE:

DATE OF ACCIDENT: _____

CLAIM NUMBER: _____

AUTO INSURANCE CARRIER: _____

CONTACT PERSON: _____ PHONE #: _____

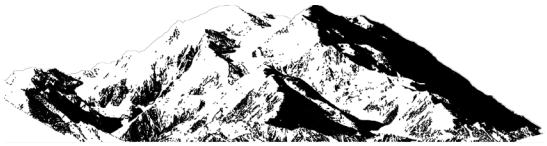
ARGEEMENT

The Undersigned hereby agrees to supply McKinley Orthopedic & Sports Medicine with the above (NEEDED) information within 5 days for the medical services provided to the above-named patient. I understand that I am responsible for all charges related to the auto accident. If this claim is a third-party claim, I will be responsible for 20% at the time of service until the initial visit is paid by the auto insurance. If there becomes a credit on the account, you will be sent a refund. McKinley Orthopedic and Sports Medicine will not accept liens or hold accounts for settlement. We will gladly setup monthly payment arrangements via our autopay system.

**** IN THE EVENT THE ABOVE INFORMATION IS NOT SUPPLIED TO MCKINLEY ORTHOPEDICS & SPORTS MEDICINE WITHIN THE SPECIFIED TIME (5 DAYS) I UNDERSTAND THAT THE ACCOUNT BALANCE WILL BECOME THE GUARANTOR'S IMMEDIATE RESPONSIBILITY ****

Patient/Responsible Party Signature: _____ Date: _____

BACK SIDE STAFF ONLY



McKinley
Orthopedic & Sports Medicine

(STAFF ONLY)

AUTO POLICY INFORMATION CONFIRMATION

Please call the Auto insurance to confirm the following information:

PATIENT ACCT# _____

SPOKE WITH: _____ PHONE #: _____

MED PAY AVAILABLE: _____

BODY PART EFFECTED: _____

DATE OF ACCIDENT: _____

AUTO INSURANCE CARRIER: _____

CLAIM NUMBER: _____

ADJUSTER NAME: _____

ADJUSTER PHONE: _____

AUTO INSURANCE CLAIMS MAILING ADDRESS:

_____

_____

Information collected & confirmed by:

X: _____ Date: _____