Advanced
MEDICAL IMAGING

3rd PARTY ACCIDENT QUESTIONNAIRE

Patient Name: Address: City/State/Zip:	Phone Number:	Patient Account #:
	Birth Date:	Service Date:

What type of accident caused illness, injury, or condition? (circle one) Automobile or Other
Have you filed, or do you intend to file a liability claim or lawsuit related to this illness, injury, or condition? Yes or No

Date of Accident: _____	Patient was (circle one):	Driver Passenger Pedestrian Bicyclist Other	
1 or 2 vehicle accident: _____	Was a ticket issued?	Yes or No	To whom: _____
Location of Accident:	Work related?	Yes or No	

PATIENT – DRIVER – OWNER INFORMATION

Patient Vehicle Insurance Company (even if passenger, pedestrian, or bicyclist) Vehicle Insurance Address: Phone:	**POLICY/CLAIM #** _____ Adjuster: _____ Phone Number: _____
Driver of Vehicle: Address: Phone: Driver's Insurance Co: Address: Phone:	**POLICY/CLAIM #** _____ Adjuster: _____ Phone Number: _____
Owner of Vehicle: Address: Phone: Owner's Insurance Co: Address: Phone:	**POLICY/CLAIM #** _____ Adjuster: _____ Phone Number: _____

OTHER VEHICLE INSURANCE INFORMATION (If applicable)

Driver of Other Vehicle: Address: Phone: Driver's Insurance Co: Address: Phone:	**POLICY/CLAIM #** _____ Adjuster: _____ Phone Number: _____
Owner of Other Vehicle: Address: Phone: Owner's Insurance Co: Address: Phone:	**POLICY/CLAIM #** _____ Adjuster: _____ Phone Number: _____

ATTORNEY INFORMATION

Name: Address:	Phone:

BRIEF DESCRIPTION OF ACCIDENT

I certify that, to the best of my knowledge, the provided information above is true and accurate.

Printed Name: _____ **Date:** _____

Signature: _____

HEALTH INSURANCE INFORMATION

I understand that Advanced Medical Imaging has a contractual obligation to submit claims to my insurance company and agree to waive any further legal and/or contractual right regarding the insurance or health plan coverage for services provided. I understand that once the 3rd party insurance carrier has settled the claim, any payments from the health insurance company will be refunded directly to them. Any deductibles, coinsurance, or copayments will be refunded back to the guarantor on your account.

Insurance Company:	Member/Policy Number: _____
	Group #: _____ Employer: _____
Address: Phone:	Subscriber Name: _____
	Subscriber Date of Birth: _____

Please initial one of the following:

_____**I request Advanced Medical Imaging to refrain from submitting any claims or information to my health insurance company related to the service(s), and I agree to assume all payment obligations for such service without regard to the health coverage I have available to me through the above listed insurance company. I understand I will be responsible for full billed charges.**

_____**I give permission to Advanced Medical Imaging to file to my health insurance in the event the 3rd party carrier does not remit payment in 45 days. I understand that I will be held personally responsible for cost of service(s) provided and any deductibles, coinsurance, or copays from my health insurance company will become my responsibility.**

I certify that, to the best of my knowledge, the provided information above is true and accurate.

Patient Signature: _____ Date: _____

Please email or fax this form along with a copy of your health insurance card (front and back) to Advanced Medical Imaging secure fax number (402) 484-4472 or email to patientinfo@amimaging.com.