



# PEARSON

Chiropractic & Rehabilitation Center

## CAR INSURANCE

**253.638.2424**

13003 SE Kent Kangley Rd., Suite 110, Kent, WA 98030

**IF YOU WISH TO BILL CAR INSURANCE, A THIRD PARTY OR AN ATTORNEY, FOR INJURIES RECEIVED DUE TO AN ACCIDENT, THE FOLLOWING QUESTIONS MUST ALL BE COMPLETED FULLY.**

YOUR NAME: \_\_\_\_\_

YOUR AUTO INSURANCE CLAIMS OFFICE NAME: \_\_\_\_\_

YOUR AUTO INSURANCE CLAIMS OFFICE ADDRESS AND PHONE: \_\_\_\_\_

INSURED MEMBERS NAME: \_\_\_\_\_

POLICY# \_\_\_\_\_ CLAIM # \_\_\_\_\_

DATE OF ACCIDENT: \_\_\_\_\_ TIME OF ACCIDENT: \_\_\_\_\_

WHERE DID THIS ACCIDENT OCCUR?: \_\_\_\_\_

WERE YOU DRIVING OR A PASSENGER: \_\_\_\_\_

WEARING SEATBELT \_\_\_\_\_ YES \_\_\_\_\_ NO

WHAT KIND OF CAR WERE YOU IN?: \_\_\_\_\_

WHAT SIDE OF CAR WAS DAMAGED?: \_\_\_\_\_

DID THE OTHER CAR STRIKE YOURS?: ( ) YES ( ) NO ( ) UNDETERMINED

WERE YOU AT FAULT/ISSUED A CITATION?: \_\_\_\_\_

**THIS SECTION PERTAINS TO THE DRIVER(S) OF THE OTHER VECHILE(S).**

DRIVERS NAME: \_\_\_\_\_

AUTO INSURANCE CLAIMS OFFICE NAME: \_\_\_\_\_

AUTO INSURANCE CLAIMS OFFICE ADDRESS AND PHONE: \_\_\_\_\_

POLICY#: \_\_\_\_\_ CLAIM#: \_\_\_\_\_

TYPE OF CARE INVOLVED: \_\_\_\_\_

DRIVER AT FAULT?: \_\_\_\_\_ ISSUE A CITATION?: \_\_\_\_\_

**ATTORNEY INFORMATION:**

HAVE YOU RETAINED AN ATTORNEY?: \_\_\_\_\_

ATTORNEY'S NAME: \_\_\_\_\_

ATTORNEY'S ADDRESS AND PHONE: \_\_\_\_\_

**THIS INFORMATION MUST BE COMPLETE IN FULL. IF YOU WERE NOT AT FAULT, WE STILL NEED YOUR AUTO INSURANCE INFORMATION COMPLETED TO DETERMINE IF YOU HAVE PERSONAL INJURY PROTECTION (P.I.P.) COVERAGE, WHICH IS A PROVISION ON YOUR POLICY TO PAY FOR MEDICAL BILLS UNTIL THE TIME OF SETTLEMENT WITH THE OTHER INVOLVED PARTIES INSURANCE COMPANY, WHO THEN REIMBURSE YOUR INSURANCE COMPANY FULLY. IF APPLICABLE, PLEASE UNDERSTAND THAT THIS IS A BENEFIT YOU PAY FOR, AND THIS IS IT'S PURPOSE; IN NO WAY WILL IT EFFECT YOUR INSURANCE PREUIM.**

**THANK YOU.**