Bodyworks
THERAPY

Motor Vehicle Accident Form

Name: _____ Date of Accident: _____

Who was at fault? (You or Other party) _____

Was the vehicle you were in, insured at the time of accident? _____

Was a police report issued? If yes, Police Report number_____

Have you gone to a hospital or seen any other doctor ( ) Yes ( ) No

If yes than where? _____

Images, i.e. MRI, Xray, Ultrasound: _____

Are your work activities restricted because of this injury? ( ) Yes ( ) No

Personal Auto Insurance or Vehicle you were in:

Name of the policy holder: _____

Relationship to the policy holder: _____

Address of insurance company: _____

Insurance company phone #: _____

Other Party's Auto Insurance Info:

Name of the policy holder: _____

Address of insurance company: _____

Insurance company phone #: _____

Adjuster's name: _____ Adjuster's number: _____
Policy #: _____ Claim #: _____

Did you retain a Lawyer? _____ Name of attorney? _____

Number of Attorney: _____

In your own works, describe the accident:

_____

_____

_____

7801 SCHOON ST. STE B ANCHORAGE AK 99518
PH:907.344.0376 FAX: 907.344.0708

Bodyworks
THERAPY

Describe your symptoms:

_____

_____

_____

I hereby authorize Bodyworks Therapy to obtain or release any information to the insurance company, attorney, or referring physician upon request. I assign payment of medical benefits to Bodyworks Therapy and understand that I am financially responsible for any charges not covered by my insurance carrier.

Print Name: _____

Patient's Signature: _____ Date: _____

7801 SCHOON ST. STE B ANCHORAGE AK 99518
PH:907.344.0376 FAX: 907.344.0708