

ACCIDENT LIABILITY POLICY

1. I understand that I am being treated for injuries sustained in a motor vehicle accident and that failure to keep my appointments may jeopardize the insurance carriers responsibility for medical costs and/or compensation for pain and suffering.
2. I understand that this office is extending me credit for treatment and that if I miss two (3) office visits without a reasonable excuse all bills may be due immediately and a \$25 missed office visit fee will be incurred.
3. I understand that if I sever ties with my attorney before settlement or my attorney will no longer represent my case, all bills may be due immediately.

Patient Signature

Date