

Date: _____

Patient Name: _____ Med Rec # / Account# _____

INJURY LIABILITY QUESTIONNAIRE

The nature of your injury may alert your medical insurance company to potential liability. Completing this form in its entirety allows **Agility Health** to provide a quick response to those inquiries and prevent delays in processing your claims.

Is this injury work related? Yes No Is this injury auto related? Yes No

Have you/do you intend to file a claim against a business or homeowner's insurance policy? Yes No



If you answered no to the above questions, it is not necessary to complete the rest of this form. Just sign and date below.

Date of injury/onset of condition / recent exacerbation? _____

Describe in detail how injury occurred. _____

Specific name & location where injury occurred (IE: store, restaurant, intersection, etc.)

Who is responsible for accident? Self: _____ Other: _____

If other, who? _____

Insurance of responsible party: Name: _____

Address: _____

Claim #: _____

Adjuster Name: _____

Adjuster Phone: _____

Personal insurance: Name: _____

Address: _____

Claim #: _____

Contact Name: _____

Contact Phone: _____

The above information is accurate and true to the best of my knowledge. I agree to immediately notify provider with any change in this information.

Patient's Signature: _____ Date: _____

Print Name: _____ (when patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required).

Signature of Legal Representative: _____ Date: _____

Print Name of Legal Representative: _____

Description of Legal Representative Authority: Parent Medical Power of Attorney (attach documentation)

Other _____ (Explain and Attach Documentation)