Dr. Wilbur Kuo and Associates Internal Medicine
Motor Vehicle Accident Waiver

Patient Name: _____

Date of Accident: _____

Claim Number: _____

Auto Ins Company: _____

Auto Ins Phone #: _____

Auto Ins Address: _____

City: _____State:_____Zip:_____

Adjuster Name: _____

Adjuster Phone #: _____

I authorize payment of medical benefits to Dr. Wilbur Kuo and Associates Internal Medicine, LLC for services provided.

If the claim has not been paid within 90 days from the date of service, I understand that I will be required to pay the balance in full.

_____

Patient Signature Date