ALAN J. ZEND, D.O.
7500 212TH ST SW., #201
EDMONDS, WA 98026
PHONE 425 775 4427 FAX 425 771 2554

CONTRACT FOR MOTOR VEHICLE ACCIDENTS

I acknowledge and understand that the office of Alan J. Zend, D.O. will be billing my Personal Injury Protection (PIP) automobile insurance for my motor vehicle accident. I agree to cooperate with filling out and returning to my insurance company any and all forms, in a timely manner, to expedite the benefits to Alan J. Zend, D.O. for my medical care pertaining to this accident

I acknowledge and understand that I am financially responsible for all outstanding amounts for my medical care that my PIP chooses not to cover. This includes, but is not limited to, findings of an Independent Medical Examination, the exhaustion of my benefits or any refusal of payment by my PIP carrier. I also understand that this payment is not contingent upon any settlement that I may receive, and it will be paid in full within two (2) months of my insurance's refusal to pay.

Date of Accident_____

_____

Printed name of Patient Today's date

_____

Signature (parent if under 18 years old)

Witness Signature_____ Date ____/____/____

Witness Name_____