

*Ding's Acupuncture and Wellness*  
15446 Bel-Red Road, Suite 405 Redmond, WA 98052  
Tel. (425) 298-3819  
E-mail: [dingsacupuncture@gmail.com](mailto:dingsacupuncture@gmail.com)  
Website: [www.dingsacupuncture.com](http://www.dingsacupuncture.com)



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**Questionnaires about PIP (Personal Injury Protection):**

Patient Name: \_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_

Adjuster's Name & Phone #: \_\_\_\_\_

PIP Insurance coverage limit:  
\$ \_\_\_\_\_

Amount of PIP coverage used as of this date?  
\$ \_\_\_\_\_

Amount of pending or unpaid but received bills?  
\$ \_\_\_\_\_

Claim #: \_\_\_\_\_

Date of Accident: \_\_\_\_\_

Name of At-Fault-Party: \_\_\_\_\_

Address to send claims to: \_\_\_\_\_

Name & Phone# of Your Attorney: \_\_\_\_\_

Please list all other doctors and/or medical professionals you have seen under this claim:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name of Patient (print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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## **Payment Policy for Auto Injury Personal Injury Protection (PIP) Cases**

PIP is required to pay at 100%. However, sometimes there are reduced amounts, delays and denials for many reasons. It is because of that, we strongly suggest you seek representation through an attorney. We will work with your attorney to get your claims paid. Please be aware, that if you choose not to seek representation of an attorney, any and all claims that remain unpaid are your responsibility. It is your responsibility to communicate with your insurance adjuster regularly to make sure your benefits have not been exhausted. If your PIP insurance is exhausted, you will be responsible for the balance of any outstanding bills for treatment. It is important to remember that you are ultimately responsible for all payments for all the services rendered whether you have health insurance, PIP or no coverage.

Unpaid balances past 30 days due will accrue a 1% monthly service charge. Balances 120 days past due will be sent to collections.

I have read and understand the above policy.

Name of Patient (print): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_