PORTSIDE COLLISION CENTER
19 N COLUMBIA STREET
PORT JEFFERSON, NY 11777

631 473 5247 46-2136485

Name_____

Address_____

Street address town zip

Cell phone _____

How did you hear about us?

Online_____Friend(please tell us who)_____

Other:_____

Claim #_____

Insurance company:_____

Year_____make_____model_____

I authorize PORTSIDE COLLISION CENTER to repair the above vehicle. If additional damages Arise, the shop will contact my insurance company for supplemental payment. If insurance is not being used, I will be contacted prior to additional work being performed. You may operate the above vehicle for the purpose of testing and repairs at my own risk. You will not be held responsible for loss or damage to veh or articles left in veh in case of fire, theft, accident or any other cause beyond your control.

X_____Date_____

Direction of Payment

I authorize the insurance company to pay the above shop directly for the cost of repairs arising from my claim.

X_____Date_____