



Auto Body Clinic, Inc.
17-19 High Street
Reading, MA 01867-3117
Phone: 781-944-0033 | Fax: 781-944-8435
Tax ID: 042694666 Exp: 5/31/2017 RS#162

Customer First Name: _____ Last Name: _____

Vehicle: _____ Vin# _____ Claim# _____

AUTHORIZATION

*** PART PRICES ARE SUBJECT TO ACTUAL INVOICES ***

I hereby authorize the repair of the above vehicle as described in the attached Estimate/Repair Order. I agree that this company is not responsible for the loss or damage to this vehicle and/or loss of articles caused by fire, theft or any other cause beyond our control, for any delays caused by the unavailability of parts or shipping delays. I also hereby grant permission to this companies employees to operate the above vehicle for the purpose of testing and/or inspection. To secure payment in the amount of the repairs thereto, an expressed mechanics lien on the above vehicle is acknowledged and I further agree to pay reasonable attorney's fee and court costs in the event that legal action becomes necessary to enforce this contract. I acknowledge that the total estimate of repairs includes all parts, labor, handling and diagnosis and agree that, if closer analysis reveals that additional repairs are necessary I will be contacted for authorization if additional repair costs are required. If NEW PARTS listed in the attached Estimate/Repair Order are NOT available, this company reserves the right to REPAIR such damaged or worn parts, where possible, the charge for which will be adjusted accordingly between the part price and the labor required. Old parts will be junked unless requested before work is begun.

Due to the complexity of the repair and the quality of the work required, we are unable to always guarantee a specific delivery time.

Term: If the insurance coverage is to be applied against partial or total payment, I acknowledge that the insurance coverage is to be applied against obtained by myself or sent in advance by the insurance company prior to release of the repaired vehicle as described.

Signature: _____ Date: ____/____/____

Original Damages: _____ **Deductible Applies:** _____ **Betterment:** _____

DIRECTION TO PAY

Insurance Company: _____

Adjuster: _____ Ins. Co. Fax#: _____

Insured:
Date of Loss:
Deductible: \$0.00

Regarding: () **Original** () **Supplement** () **Towing**

I hereby assign my policy benefits for collision/comprehensive repairs and authorize the above Insurance Company to pay directly to Auto Body Clinic for damages

Signature: _____ Date: ____/____/____

*******Please make payment directly to Auto Body Clinic*******