1109 N Sickles Dr
Tempe, Az 85281
(480) 248-9049
www.visioncollision.com

VISION COLLISION
AUTO BODY PAINT & REPAIR

Repair Authorization Form

Name: _____ Phone: _____ Email: _____

Address: _____ City: _____ Zip: _____ Preferred Contact: _____

Vehicle Year: _____ Make: _____ Model: _____ Color: _____

Prior Damage: _____

Insurance Company: _____ Date of Accident: _____

Claim Number: _____ Adjuster Name: _____ Phone: _____

I hereby authorize Vision Collision, its employees, and its designated third-party providers to complete the repair work on my vehicle, as outlined in estimate number _____. I also authorize the purchase of parts and materials necessary for said repairs. I give Vision Collision Employees and contracted third-party providers permission to operate the vehicle described herein on streets, highways, or elsewhere for purpose of testing and inspection.

I understand that Vision Collision is not responsible for loss or damage to my vehicle and/or articles left in vehicle in case of fire, theft, or any cause beyond our control. Please remove your personal belongings from the vehicle, including your child safety seats, medications, firearms, and anything that may be damaged in exposure to extreme heat. Additionally, once your vehicle is prepared for paint, we will not be able to give you access to it, so please remove anything you think you will need during your repair. Notify us if your vehicle uses alternate fuel.

Vehicles towed or driven in, then deemed a total loss, or moved to another facility for any reason by the customer or Insurance Company may be subject to administrative, lot, debris cleanup charges, and/or estimate fees. Any labor, towing, or lift inspection fees must be paid before a vehicle leaves Vision Collision. I agree that if I cancel the work authorization before work is completed, I am responsible for paying for all work completed before notice of cancelation, as well as any parts that have been purchased already.

I understand that my bill must be paid in full before my vehicle will be released to me. Vision Collision accepts cash, credit cards, and insurance check payment. Any alternate payment arrangements must be made in advance, in writing, with Todd Wright, Owner of Vision Collision. Prior written notice must be given if return of used or damaged parts is desired by the customer.

I grant Limited Power of Attorney to Vision Collision, authorizing them to endorse any checks received on behalf of the vehicle owner(s).

Initial: _____
Date: _____

Please sign and return this document to our office, via email to todd@visioncollision.com, or via fax to (206) 600-4533.
Work cannot begin until we receive this signed form.

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I understand that every effort will be made to complete my vehicle within the timeframe discussed. However, I also understand that Vision Collision cannot be held responsible for delays that occur as the result of parts availability, insurance company requirements, additional damage discovered in the teardown process, weather delays, and other circumstances unforeseen and uncontrollable.

I understand that it is possible that once vehicle teardown begins, additional damage may be discovered. In this case, a supplemental claim will be submitted on my behalf to my Insurance Company and this amount will be included in my final total. If this is not an insurance repair, I understand that I will be contacted for authorization in the event that additional work needed changes the estimate price by more than 10%.

I understand that I will incur storage charges at a rate of $200 per day inside and $60 per day outside if I do not pick up my vehicle within 2 business days of receiving notification that my repairs are complete. I understand that these storage fees are not usually covered by insurance companies and that they will be my responsibility.

Direction of Payment (Choose one by initialing accompanying line):
____ I authorize _____ Insurance Company to pay Vision Collision directly the complete costs of my claim-related repair job, including supplements. Vision Collision will communicate with the Insurance Company directly. In the event the Insurance Company or its representative inadvertently mails the settlement /supplement check to me in error, I hereby agree to notify Vision collision immediately, and I agree to deliver such check to the repair facility within 24 hours of my receipt of such check. I further agree to assume responsibility for the final total should payment not be made to Vision Collision within 30 days.

____ I will communicate with my Insurance Company. Payment of my claim will be made directly to me. I understand that I am responsible for paying for all repairs and supplements and will pay Vision Collision directly.

____ This repair is not part of an insurance claim.

I attest that the designation of Vision Collision as the provider of these repairs is my own choice. I affirm that I am aware that I was free to choose any provider to repair my vehicle.

I certify that I am the true and lawful owner of the vehicle identified above, or the authorized representative of the owner of the vehicle identified above.

Signature: _____ Date: _____

Printed Name: _____

How did you hear about us? _____

Initial: _____
Date: _____

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