

PERSONAL INJURY INFORMATION

Today's Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Social Security # _____
Address _____ City/State _____ Zip _____
Telephone (home) _____ (work) _____ (cell) _____

ATTORNEY INFORMATION

Name _____ Phone # _____ Extension _____
Address _____ City/State _____ Zip _____
Telephone # _____ Injury verified by _____
Contact Person _____

A lien will be required for any balance carried on your account. Accepting a lien on your account does not substitute prompt payment of your balance. We will, as a courtesy, file your insurance claims. However, we will require that your balance be resolved with in 90 days from the treatment date. Monthly payment agreements can be made if needed.

CARRIER INFORMATION

Will your Private Health insurance be billed? Y N Explain _____

Your Auto Carrier _____ Date of Accident _____ Were you at fault? Y N
Insured persons name: _____ Date of Birth _____ Social Security # _____
Carrier Address _____ City/ST _____ Zip _____
Carrier Phone Number _____ Do you Have MedPay?: Y N Amount:\$ _____
Adjuster _____ Subrogation Y N Un and Under insured \$ _____
Claim Number _____

Other Parties Auto Carrier _____ Insured's Name _____
Carrier Address _____ City/ST _____ Zip _____ Phone _____
Adjuster _____ Prompt pay? Y N _____
Claim Number _____

INJURY INFORMATION

Date of Injury _____ Time _____ AM PM
Place of Injury _____
Do you have an Attorney ? yes no Name of Contact person _____
How did accident happen? ^{Form} _____
₀₀₃ _____
Have you seen a physician for this condition? yes no
Referring Doctor's Name _____ Phone# _____
Do you have any previous injuries, if yes, please list for the therapist.

AUTHORIZATION

I hereby assign, transfer, and set over to STEVENSVILLE PHYSICAL THERAPY all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits only to the parties listed above, if conditional authorizations are needed please notify the receptionist. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance.

Patient's Signature _____ Date _____

HPT USE:
____ Attorney Contacted _____ Lien Signed _____ Monthly Payment Plan Signed _____ Auto Insurance contacted _____