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 DRUMMOND 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