PLEASE MAKE SURE YOU PROVIDE US WITH ALL OF THE FOLLOWING INFORMATION

WORK RELATED INJURY

Date of Injury: _____/_____/_____ Employer at the time of injury: _____

Employers Address: _____

Insurance Company: _____ Claim Number: _____

Insurance Address: _____

Claim Manager: _____ Phone: (_____) _____-_____ ext. _____

MOTOR VEHICLE ACCIDENT

Date of Accident: _____/_____/_____ Insurance: _____ Insurance Phone: (_____) _____-_____

Insurance Address: _____

Claim Manager: _____ Phone: (_____) _____-_____ ext. _____

Claim Number: _____ Are they currently paying on your claim? _____

Attorney Name: _____ Phone: (_____) _____-_____ ext. _____

MVA Financial Policy: You are responsible for all charges incurred. If your MVA claim is denied or is not open, you are responsible for payment at the time of service.

If your PIP is maxed, we will bill your health insurance.

If you are being treated as part of a personal injury (3rd party) lawsuit or claim, you will be required to pay $25.00 per office visit. If your claim is not settled in 6 months, the balance may be considered due at PhysioCare's discretion. If the legal settlement does not sufficiently cover the costs incurred at PhysioCare, you are still responsible for the remaining balance. When the claim is settled, ALL unpaid fees are your responsibility and due immediately. If you are being treated as part of a personal injury lawsuit, we cannot bill your attorney. We cannot bill the 3rd party. You are ultimately responsible for reimbursing PhysioCare at the time of settlement.

_____

Patient Initials

Assignment, Release and Financial Agreement: I authorize treatment of the person named above and agree to pay all fees for such treatment. I hereby authorize my insurance benefits to be paid directly to the provider of service and I am financially responsible for non-covered services. I also authorize PhysioCare to release any information to referring/consulting physicians or other health care providers as deemed appropriate to facilitate my/our care. I agree that I will not withhold or delay payment if my insurance company denies payment on any of my charges. I agree to comply with the terms and conditions as outlined in the financial policy form. I hereby acknowledge that I have been offered a copy of the PhysioCare Notice of Privacy Practices.

_____ _____ _____

Patient Signature Parent/ Guardian Signature Date