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# MOTOR VEHICLE ACCIDENTS & NON WORK RELATED ACCIDENTS

## Insurance Information

It is a patient's responsibility to know their Insurance benefit for PT services, as a courtesy our billing department will confirm policy benefits for our records and may review them with you. Please ask if you have any questions or do not understand your insurance coverage.

Patient Name: _____ Date_____

Auto Insurance Information for MEDICAL PAYMENTS (Med-Pay) coverage:

Auto Ins. Co _____ Claim # _____ Claim Manager_____

Phone #: _____ Date of Accident: _____

Name of Policy Holder: _____

Do you have an attorney for this claim? Yes No If yes, complete the following:

Attorney's Name: _____ Phone #: _____

**ASSIGNMENT OF BENEFITS FOR MED-PAY CLAIMS:**

**I, _____request and hereby give _____**
**(Patient / Policy Holder) (Insurance Company)**

**authorization to pay Active Rehab Services DIRECTLY for any Physical Therapy treatment I receive pertaining to the above Motor Vehicle Accident. I also understand, that I cannot and will not at any time, request payment be sent directly to me from the auto insurance company. If payment is inadvertently sent to me, I will bring the payment to Active Rehab Services immediately upon receipt of payment. Failure to do so will result in this account being sent to our Collection Agency immediately.**

**Please be sure your account balance with us is paid before you settle your accident claim..**
**You are responsible for paying any account balance remaining at the time of settlement.**

**Signature_____ Date_____**

**If we do not receive payment for services through your accident claim, we may bill your private insurance. Please provide your insurance information below:**

**Primary Insurance** Physical Therapy Coverage? Yes No

Insurance Co. Name: _____ Phone#: ( ) _____ Insured's Name: _____

ID # _____Group# _____ Insured's SS#: _____ Insured's DOB: _____

Relation: _____ Insured's Employer & Address: _____

Deductible: _____ Amt. Met: _____ CoPay: _____

Visit Limit: _____ Auth Needed: _____ Auth Number: _____

**Secondary Insurance** Physical Therapy Coverage? Yes No

Insurance Co. Name: _____ Phone#: ( ) _____ Insured's Name: _____

ID # _____Group# _____ Insured's SS#: _____ Insured's DOB: _____

**Authorization for Payment**

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this physical therapy office will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to this physical therapy office will be credited to my account on receipt. I also give this office power of attorney to endorse checks made out to me to be credited to my account. **However, I clearly understand and agree that I am personally responsible for payment for all services rendered me.** I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. Collection fees and/or interest fees may apply on any unpaid account balance.

**By signing below, I acknowledge that I understand & agree to the insurance information that Active Recovery Physical Therapy has discussed with me today. I also agree to pay the deductible amount and any co-payments that are due at the time of my visit unless payment arrangements are made.**

_____ _____

Signature Date



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