Motor Vehicle Accident Form

Please complete ***all areas*** of this form if your injury is related to a Motor Vehicle Accident.

Patient Name: _____ Date of Birth: _____

Date of Accident: _____ State: _____

Claim #: _____ Were you at fault for this accident?: ☐ YES ☐ NO

Injured Body Part(s): _____

Have you been treated at another facility for injuries resulting from this accident?: ☐ YES ☐ NO

Name of YOUR Auto Insurance Company: _____

Auto Insurance Phone Number: _____ Ext._____

Insurance Agent/Main Contact Person: _____

Phone Number (if different from above): _____Ext._____

Do you have Medical Coverage (Med-Pay) or Person Injury Coverage (PIP) with your Auto Insurance?

☐ YES – Amount: $_____ ☐ NO, IT'S EXHAUSTED ☐ NOT ON POLICY

NOTE: If you do not have medical coverage available you must provide proof of none coverage. (i.e., exhaustion letter, declarations page, a letter from your auto insurance company stating there is no medical coverage available). This will ensure that your health insurance company pays the correct amount for all of your physical therapy visits, lessening your personal responsibility at the end of your treatment.

Do you have an attorney?: ☐ YES ☐ NO

If yes, please complete the following:

Attorney Name: _____ Company: _____

Phone Number: _____ Ext._____

NOTE: If you have medical coverage available with your auto policy, a payment agreement will need to be signed by your attorney prior to beginning physical therapy treatment.

ATTENTION: If you obtain an attorney at a later time while you are still being treated at our facility you MUST NOTIFY OUR STAFF IMMEDIATELY.

Patient Signature: _____ Date: _____