Personal Injury Accident Form

*Please complete **all areas** of this form if your injury is related to a Personal Injury Accident **OR** if your case has not been settled.*

Patient Name: ________________________________ Date of Birth: _______________

Date of Accident: __________________ State: _____________

Claim Number: ____________________________

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

Please complete the following:

Name of Insurance being billed for Physical Therapy: _______________________________

Insurance Agent / Main Contact Person (if applicable): _____________________________

Phone Number: _______________________ Ext: _______________

Do you have an attorney? ☐ YES ☐ NO

If yes, please complete the following:

Company Name: ____

Attorney Name: ____

Phone Number: ______________________________ Ext. _________________

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

<u>NOTE</u>: If any claims billed to insurance are denied due to this Personal Injury Claim, complete accumulated charges will be billed to you, the patient.

Patient Signature: ____ Date: _______________