AUTO OR NON-WORK RELATED ACCIDENT
Patient & Payor Information Form

All Patients or Patients' Legal Representative, please complete all Sections

(1) Patient: (Full Legal Name or as on Insurance Card)

_____ **Date of Birth** _____/_____/_____

Name: Last First Initial

Emergency Contact Name _____ **Number** (_____) _____-_____

(2) Patient's Doctor: Please list the Doctor who referred you to therapy below.

_____ **Office Phone:** (___) ____-_____

Referring Dr's Name: Last First Initial MD, DO, DDS, Other

_____

Address: Street City,State Zip Code

(3) Auto or Non-Work Accident Claim—

The Claim will be paid by: ____ **Your Personal Car Insurance** ____ **Liability Claim (Another Person's Insurance)**

Insurance Company: _____ **Claim #:** _____

Adjustor's Name: _____ **Phone #** (____) ____-_____ **FAX #** (____) ____-_____

Claim Mailing Address:_____
Street City State Zip Code

If pursuing litigation:

Name of Law Firm : _____ **Name of Attorney**: _____

Address of Law Firm:_____
Street City State Zip Code

Phone # of Law Firm: ( ) _____-_____ **Fax #** ( ) _____-_____

Sign: A or B

A) I understand that I and my attorney must agree to the terms of Madden Physicla Therapy "Letter of Protection/Lien" in order for a liability claim to be considered as a payment source. Patient's Signature:

_____

B) I understand that if I am using my personal car insurance I must assign payment benefits to Madden Physical Therapy and be prepared to pay should I exhaust the medical funds: Patient's Signature:

_____

All Patients or Patients' Legal Representative Please Sign Section 7 on Page 2

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(4) Medical Insurance Information(please provide a copy of Insurance card and complete this section in the event that your Auto or Non-Work Accident claim is denied)

Ins. Co. Name: _____ **Ins. Co. Phone #:** _____

Insured's Name: _____ **Insured is** ____**Patient** ____**Spouse** ____**Parent**

Sex: M F **Birthdate:** ____/____/____

Patient ID #: _____**Group. #** _____ **Policy/Plan #:** _____

Claims Mailing Address: _____
Street City State Zip Code

Employer Name: _____ **Employer Phone # (** **)** _____- _____

Address: _____
Street City State Zip Code

(5) Payment Authorization: *(Initials required for all 3 statements)*

_____ **Assignment of Insurance Benefits**

Initials **I authorize that the payment of my insurance benefits be made directly to Madden Physical Therapy for any services that are reimbursable by my insurance company, if I have one.**

_____ **Guarantee of Payment**

Initials **I understand that all payments designated as 'the patient's responsibility' such as co-insurances and deductibles are due and payable at the time of service or statement receipt. I guarantee I will pay the amount deemed "my responsibility" by the billing statement due date.**

_____ **Health Insurance Option** (Copy of Insurance Card Required)

Initials **I agree to Madden Physical Therapy to file my Health Insurance within the required claims filing period should my Personal Auto or the other party's insurance deny the claim, exhaust the benefits or fail in anyway to pay per the agreed upon terms**

_____ **Certification of Information**

Initials **I certify that the information I have provided Madden Physical Therapy for payment including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.**

(6) Attendance Policy:

ATTENTION!

In order to provide our patients with the best possible care, we maintain scheduled appointments. *If you cannot make a scheduled appointment, PLEASE contact us 24 hours before your scheduled time.* This will allow us to adjust our schedule appropriately.

_____ATTENDANCE POLICY
Initials

Individuals who attend 100% of their scheduled appointments will receive a free MADDEN PHYSICAL THERAPY gift. ***PATIENTS WHO CANCEL 3 TIMES OR NO-SHOW 2 TIMES WILL BE DISCHARGED.***

(7) Signature/ Date:

_____ _____
Patient or Legal Representative's Signature **Today's Date**

All Patients or Patients' Legal Representative Please Sign Section 7 on Page 2