PERSONAL INJURY INFORMATION

Today's Date PATIENT INFORMATION Birthdate_____ Social Security #___ Address _______
Telephone (home) ______ ____City/State_____ ATTORNEY INFORMATION Name ______City/State______Zip_____ Address Injury verified by Telephone # ___ Contact Person ____ A lien will be required for any balance carried on your account. Accepting a lien on your account does not substitute prompt payment of your balance. We will, as a courtesy, file your insurance claims. However, we will require that your balance be resolved with in 90 days from the treatment date. Monthly payment agreements can be made if needed. CARRIER INFORMATION Will your Private Health insurance be billed? Y N Explain_____ Your Auto Carrier Date of Accident Were you at fault? Y N Insured persons name: Date of Birth Social Security # City/ST_ Carrier Address ___ Carrier Phone Number_______ Do you Have MedPay?: Y N Amount:\$_____ _____Subrogation Y N Un and Under insured \$_____ Adjuster ___ Claim Number ____ Other Parties Auto Carrier____ Insured's Name Carrier Address_____ Adjuster_____ ____ Prompt pay? Y N Claim Number INJURY INFORMATION Date of Injury ___ Place of Injury ____ Do you have an Attorney ? yes no Name of Contact person _____ How did accident happen? Form Have you seen a physician for this condition? yes no Phone# Referring Doctor's Name Do you have any previous injuries, if yes, please list for the therapist. **AUTHORIZATION** I hereby assign, transfer, and set over to PHYSICAL THERAPY SPECIALISTS OF FLORENCE all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy. I authorize the release of any medical information needed to determine these benefits only to the parties listed above, if conditional authorizations are needed please notify the receptionist. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am financially responsible for all charges whether or not they are covered by insurance. Patient's Signature HPT USE: _____Attorney Contacted _____Lien Signed _____Monthly Payment Plan Signed ____Auto Insurance contacted

Form 003