BPTW AUTO OR NON-WORK RELATED ACCIDENT
Patient & Payer Information Form

<u>All</u> Patients or Patients' Legal Representative, please complete all Sections

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

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Name: Last First Initial Sr. Jr.

Patient's Doctor: Please list the doctor who referred you to therapy or your Primary Care doctor

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

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

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:

I understand that I and my attorney must agree to the terms of Berryville Physical Therapy & Wellness' "Letter of Protection/Lien" in order for a liability claim to be <u>considered</u> as a payment source.

I understand that if I am using my personal car insurance I must assign payment benefits to Berryville Physical Therapy & Wellness and be prepared to pay should I exhaust the medical funds:

Medical Insurance Information must on file on regular intake forms in the event that your Auto or Non-Work Accident claim is denied.

Patient's Signature: ____

<u>Payment Authorization: (Initials required for all 4 statements)</u>

__________ **Initials** — **Assignment of Insurance Benefits** - I authorize that the payment of my insurance benefits be made directly to Berryville Physical Therapy & Wellness for any services that are reimbursable by my insurance company, if I have one.

_________ **Initials** — **Guarantee of Payment -** 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 <u>or</u> statement receipt. I guarantee I will pay the amount deemed "my responsibility" by the billing statement due date.

_________ **Initials** — **Health Insurance Option** (Copy of Insurance Card Required) I agree for Berryville Physical Therapy & Wellness 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

_________ **Initials** — **Certification of Information** -I certify that the information I have provided Berryville Physical Therapy & Wellness for payment including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.

____ _______/______/________________

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