PHYSICAL THERAPY of Leicester, Inc.

Physical Therapy of Leicester 149 New Leicester Highway Asheville, NC 28806 Phone: 828-225-3838 Fax: 828-225-3839

Intake Form- Motor Vehicle Accident

In order to begin treatment, please provide the following:

(1) A copy of the accident report. *You can get this from the insurance company, the police/highway patrol, or the internet.*

(3) Physician referral if we will be billing insurance

(2) One of the following in order to begin treatment *(check one of the options below and provide a copy)*

___ Claim number plus name& contact information for insurance adjuster of all insurance companies we will be billing for your treatment.
___ Letter of Representation signed by attorney
___ Credit card that we may charge at the time of each visit *($125 for initial evaluation, $65 regular visits)*

Card type:_____ Number:_____ _____ _____ _____ Expiration:_____ cvv:_____

Injured Party Information

Name: _____ **Date of Birth:** _____

Date of accident _____ **Place of accident** _____

Did you visit the emergency room? Y___ N___ Name of hospital:_____ Date:_____

Have you seen a primary care doctor? Y___ N___ Name:_____ Date(s):_____

Have you seen a specialist? Y___ N___ Name:_____Date(s):_____

Have you seen any other health care providers since the accident/related to the accident? Y___ N___
If so, please list below:

Name:_____ Type of provider:_____ Date(s):_____

Name:_____ Type of provider:_____ Date(s):_____

Do you have health insurance? Y___ N___

Company:_____ Policy #:_____

Do you have Medpay coverage as part of your automobile insurance? Y___ N___ Benefit amt:$_____

Company: _____ Policy#:_____

Is there any other insurance company that may be liable for expenses related to your accident? Y___ N___

Company: _____ Policy#:_____

Do you have a lawyer? Y___ N___

Name: _____ Phone: _____

Did you have pre-existing injuries that were aggravated by this accident? Is so, please list them here. This will not affect your ability to get treatment.

_____

At-Fault Party Information

At-Fault Party:_____

At-Fault Party's Insurance Company: _____ Claim Number: _____

Adjuster: _____ Phone: _____ Fax:_____

Address: _____

AGREEMENT

_____ (*initial here)* I hereby assign any and all insurance benefits for medical payment for treatment received at PTOL that is related to the aforementioned car crash to PTOL, and hereby direct payment of such insurance benefits, whether it is health insurance, self funded benefit plan benefits, liability insurance, uninsured insurance, underinsured insurance, Medicare or Medicaid to PTOL for application to my account in payment of services rendered. PTOL will, AS A COURTESY, attempt to obtain payment from my insurance company for services provided.

_____ *(initial here)* I acknowledge that I am ultimately responsible for discerning my financial responsibility according to any insurance policy as well as for any and all balances left unpaid on my account, whether by copay, coinsurance, deductible or non-payment by insurance. If deemed necessary, a payment plan may be set forth by PTOL for reimbursement of charges incurred for services rendered. Payment in full of all balances owed may be demanded at any time and are payable by the date set forth by PTOL. Any late or non- payment of charges will result in late and/or interest fees being added to my account balance at a rate of 1.5% per month, as well as my account being sent to a collection agency if payment is not made according to terms set forth by PTOL. A 40% collections fee will be added to my account balance in the event a collection agency becomes involved in recouping charges owed.

_____ *(initial here)* I agree and request that payment of insurance benefits for my physical therapy services be made to Physical Therapy of Leicester, Inc (PTOL) directly. As a courtesy, PTOL will attempt to make reasonable efforts to obtain payment from the responsible insurance company for services provided.

I certify that the information above is true and correct to the best of my knowledge.

Patient or Guardian Signature: _____ Date: _____

Printed Name: _____ Relationship to patient: _____

COMPLETION CHECKLIST

In order to process this form, all requested items must be included and all boxes must be filled out

_____Each blank is filled out. If it doesn't apply to me, I've written "N/A" for "not applicable".
_____Accident report
_____Physician referral if we'll be submitting claims to insurance
_____Letter from lawyer
_____Claim # plus name & contact information for adjuster at each insurance company
_____Initial and sign all lines above