AUTO ACCIDENT

PATIENT INFORMATION

Patient____
Last Name First Name Middle Initial
Home Address____
Address City State Zip
Home Phone ( )_________-___________Cell Phone ( )________-___________
May we leave messages at these phone numbers concerning your appointments/account? YES NO

Date of Injury/Surgery______/______/______Email____

Date of Birth _______/_______/_______ Age________ **Social Sec.#** _______-_______-________

Male ☐ Female ☐ **Marital Status:** ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Separated

Is there an Attorney involved in your case? YES NO
***If yes, Peak Physical Therapy will not hold your account for settlement. You will be required to provide your private health insurance & make timely monthly payments on any unpaid balances.**

Employment Status: ☐ Employed ☐ Unemployed ☐ Retired
Employer_____________________________________Occupation_____________________________________
Employer Address____ Phone # ( )_________-___________

Responsible Party Name:____ ☐ self ☐ spouse ☐ parent ☐ other

Have you contacted your Auto Insurance regarding this accident? YES NO
Your Auto Insurance Company_____________________________________ Phone #( )_________-___________
Insurance Policy Number____
Claim Number_________________________________ Adjuster Name:_________________________________
Address____ Phone # ( )________-__________

PRIVATE HEALTH INSURANCE
Insured's Name___________________________________ Policy # _________________________________
Insured's Date of Birth________/__________/____________ Insured's SS# ________-___________-____________
Insurance Provider__________________________________ Phone Number ( )_________-_________

Referring Physician ____ Phone # ( )________-___________
Date Last seen by physician_____/_____/_______

Emergency Contact____ Relationship ☐ spouse ☐ parent ☐ other
Address____ Phone #( )_______-_______

How did you hear about Peak Physical Therapy? ***(Circle one)***
Physician Family/Friend Previous Patient Advertisement Other__________________________________

Our office will file insurance claims for all reimbursable services to your auto insurance carrier. **Peak Physical Therapy will not bill third party MVA insurance.** You are responsible for all deductible, co-pay, and non-covered services amounts. If at any time your benefits are terminated/denied for any reason you consent to provide your private health insurance and allow Peak Physical Therapy to bill your private insurance for any unpaid balances. If unpaid balances are not paid or in the process of being paid off your account will be turned over to a collection agency within 180 days of your last date of service. I hereby consent to such physical therapy procedures as may be rendered by Peak Physical Therapy. There is also consent for authorization of all insurance benefits to be paid directly to Peak Physical Therapy, and assumption of all financial responsibility for the balance of charges not included in the insurance coverage. Peak Physical Therapy has the authority to release any information necessary to the insurance company for the processing of medical claims and to photograph for medical purposes only. Peak Physical Therapy is released from disclosure of the patient's records as provided by this paragraph.

____ ________/_________/_________
Signature of Patient/Responsible Party Date

NO-SHOW, CANCELLATION POLICY

Our "No-Show, Cancellation Policy" is as follows: All patients who do not cancel their appointment within 24-hours or more of their scheduled appointment will be charged **$20.00** at their next appointment. This fee can be waived for patients who re-schedule their appointment with in that week.

Patients who do not show up to their appointment and do not call to cancel will receive a **$25.00** "No-Show" fee.

I HAVE READ AND UNDERSTAND THE "No-Show, Cancellation Policy"

______________________________________ ______/______/______

PATIENT/RESPONSIBLE PARTY SIGNATURE **DATE**