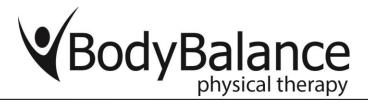


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AUTO OR NON-WORK RELATED ACCIDENT

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

(1) Patient: (Full Legal Name or as on Ins	urance C	Card)			
Name: Last First		Initial	Sr. Jr.		
		Initial	Sr. Jr.		
Address: Street Apt#	City	St	ate	Zip Code	
Phone: ()   ()     Home  Mobile		() Work	(	) Emergency	
Email:					
Sex: M F Birthdate:/_	/		S.S #/_	/	
(2) Condition to be treated in Physical Th	nerapy:				
Auto Accident? No	Yes	Date of Accide	ent//		
Other Non-Work Related Accident? No	Yes	Date of Accide	ent//		
Did this Condition Result in Surgery? No	Yes	If Yes Date of	Surgery/_	/	
Have You Had PT for this Condition? No	Yes	If Yes Where?			
Have You Had Chiropractic Services No for this Condition?	Yes	If Yes Where?			
(3) Patients Doctor					
Referring Doctor:		-			
Primary Doctor:		_			
(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:	Ins	sured isPat	ientSpouse	Parent	
Birthdate:// of person on th	ne card				
Patient ID #:Group. #	Po	olicy/Plan #:			



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## AUTO OR NON-WORK RELATED ACCIDENT

(5) Auto or Non-Work Accident Claim—					
The Claim will be paid by: Your Personal Car Insu	ance (Medical Covera	age)			
Insurance Company:	Claim #:				
Adjustor's Name:	Phone # ()	FAX # ()			
Claim Mailing Address:					
Street	City	State	Zip Code		
The Claim will be paid by: 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 and/or B					
A) I understand that I and my attorney must agree to the terms of Body Balance Physical Therapy "Letter of Protection/Lien" in order for a liability claim to be <u>considered</u> 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 Body Balance Physical Therapy and be prepared to pay should I exhaust the medical funds:					
Patient's Signature:					



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## AUTO OR NON-WORK RELATED ACCIDENT

(6) Payr	nent Authorization: (Initials required for all 4 statements)
	_ Assignment of Insurance Benefits
Initials	I authorize that the payment of my insurance benefits be made directly to Body Balance 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 <u>or</u> 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 Body Balance 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 Body Balance Physical Therapy for payment including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.

(7) Signature/ Date: Patient or Legal Representative's Signature Today's Date