AUTO OR NON-WORK RELATED ACCIDENT
Patient & Payor Information Form
***All* Patients or Patients' Legal Representative, please complete all Sections**
The Center for Balance

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

Name: Last First Initial Sr. Jr.

Address: Street Apt# City State Zip Code

Phone: (_____) _____-_____ (_____) _____-_____ (_____) _____-_____ (_____) _____-_____
Home Mobile Work Emergency

(2) Patient **Sex: M F** **Birthdate: _____/_____/_____**

S.S # _____/_____/_____ **Legal Photo ID # _____**
(Driver's License, Passport, Other State/Federal Photo ID)

(3) Condition to be treated in Physical Therapy: _____

Auto Accident?	No	Yes	Date of Accident ____/____/____
Other Non-Work Related Accident?	No	Yes	Date of Accident ____/____/____
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 for this Condition?	No	Yes	If Yes Where?_____

(4) Patient's Doctor: Please list the Doctor who referred you to therapy below.

Referring Dr's Name: Last First Initial MD, DO, DDS, Other **Office Phone:** (____) _____-_____

Address: Street City,State Zip Code

All Patients or Patients' Legal Representative Please Sign Section 9 on Page 3

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(5) 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: A or B

A) I understand that I and my attorney must agree to the terms of The Center for Balance's "Letter of Protection/Lien" in order for a liability claim to be considered 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 The Center for Balance and be prepared to pay should I exhaust the medical funds:
Patient's Signature: _____

(6) 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: _____ **Insured is ____Patient ____Spouse ____Parent**

Sex: M F **Birthdate:** _____/_____/_____

Patient ID #: _____**Group. #** _____ **Policy/Plan #:** _____

Claims Mailing Address: _____
Street City State Zip Code

Employer Name: _____ **Employer Phone # ( ) _____- _____**

Address: _____ _____
Street City State Zip Code

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(7) Medications : (This includes prescriptions (from your doctor), over the counter drugs, herbal and nutritional supplements)

Separate List Provided Yes No If, No please complete this section

Medication/Drug Name	Dosage	Number of Times Per Day

(8) Payment Authorization to The Center for Balance: *(Initials required for all 3 statements)*

_____ **Assignment of Insurance Benefits**

Initials **I authorize that the payment of my insurance benefits be made directly 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 or 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 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 for payment including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful.**

(9) Signature/ Date:

_____ _____

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

All Patients or Patients' Legal Representative Please Sign Section 9 on Page 3