KECK PHYSICAL THERAPY
271 Old Barn Road, Unit C, Hendersonville, NC 28791
Office: 828-890-4905 FAX: 828-890-8123
WWW.KECKPT.COM

Motor Vehicle Accident

Please provide the following information in order to begin treatment:

Injured Party Information: Please write N/A if not applicable.

Name: ____ Date of Birth: ___________________

City/State of Accident: ______________________________ Date of Accident: ________________

Did you visit the emergency room? _____ No _____ Yes Hospital: _______________________

Have you seen your primary care Physician related to this accident? _____ No _____ Yes

Have you seen a specialist related to this accident? _____ No _____ Yes

Do you have health insurance? _____ No _____ Yes Policy #: _______________________

Do you have Medpay coverage as part of your automobile insurance? _____ No _____ Yes

Company: ________________________________ Policy: ________________________

Do you have a lawyer? _____ No _____ Yes

If so, Name: _____________________________________ Phone: ________________________

Claims Adjuster Name: ____

Insurance Company: ____

Phone Number of Insurance Contact: ____

Claim Number: ____

At-Fault Party Information:

At-Fault Party Name: ____

Claims Adjuster Name: ____

At-Fault Party's Insurance Company: ____

Phone Number of At-Fault Insurance Contact: ____

Claim Number: ____

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AGREEMENT

For Motor Vehicle Accident

______ (initial here) I hereby assign any and all insurance benefits for medical payment for treatment received at Keck PT that is related to the car accident to Keck PT, 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 Keck PT for application to my account in payment of services rendered. Keck PT 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 Keck PT 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 Keck PT. 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 Keck PT. 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 by made to Keck Physical Therapy directly. As a courtesy, Keck PT 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: ___________

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Authorization for Release of Medical Records to Insurance Company for

Motor Vehicle Accident

Today's Date: ________________________________

Patient Name: ________________________________ Date of Birth: __________________

I hearby authorize Keck Physical Therapy to release medical records or any diagnostic reports to insurance companies associated with my diagnosis.

Patient Signature: ____

Date: ____

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