



Welcome to Spooner Physical Therapy! We are aware that you have been injured in a Motor Vehicle Accident. It is our goal at Spooner Physical Therapy to:

- **Improve your ability to move**
- **Reduce your level of pain**
- **Restore your functional ability**
- **Prevent further injury and/or loss of movement**

You will need to complete various informational documents at the time of your evaluation regarding your accident in order that we can assist you in every way possible to understand your options in regard to payment for your treatment, and how it relates to the settlement of your case. If you have already retained an attorney in this matter, Spooner Physical Therapy will work with your attorney to obtain the best possible settlement that will benefit you in your case.

It is imperative that you inform your therapist that you are seeking treatment from injuries sustained in a motor vehicle accident on your first initial evaluation and treatment. This will allow the therapist to document this information into his or her medical notes when you are being treated. Such information in your medical records will substantiate the fact that your medical treatment was a direct result of the injuries you received in the motor vehicle accident, and this is extremely important to your case.

In that light, Spooner Physical Therapy will do everything it can to assist you in getting your charges paid in full. Spooner Physical Therapy allows you to choose from the following alternatives for payment of your bill:

- **Med Pay or PIP (Personal Injury Insurance) or UIM (Under-Insured Motorist Insurance). This is your own automobile insurance which you have purchased. You will NOT be penalized for using your own automobile insurance for payment of your medical bills. Normal limits are \$1,000, \$5,000 or \$25,000 per person. You can verify the total amount of your Med Pay Coverage by checking the “Declarations Page” furnished to you by your insurance company under “Coverage & Limits” or calling your agent.**
- **Third Party Insurance (the automobile insurance company of the party who caused the accident and your injuries)**
- **Health Insurance**

You can designate which of the above plans you wish us to bill on your behalf. It can be more than one; i.e., bill Med Pay, PIP or UIM first, and upon the exhaustion of those benefits, bill Health Insurance.

If you do not have Health Insurance or Med Pay, we are also able to recover payment through the Third Party’s Insurance (the automobile insurance company of the party at fault).

While every state has its own Statutes, the State of Arizona allows you the previously stated options regarding medical bill payment for your motor vehicle accident. Arizona Statutes allow all medical treatment to be billed at the facility’s usual and customary charges.



In order for us to receive payment for our services, we are required by Arizona law to file a Lien with the Maricopa County Recorder's Office, and to notify you, the patient, your attorney if you have retained one, and the automobile insurance company of the third party (the party's automobile insurance of the person who caused the accident) that we have provided medical care and treatment to you.

This lien WILL NOT affect your credit unless we do not receive payment for our medical services. It is merely a requirement of the State of Arizona to assure that we, as your medical provider, will be paid in full for our services provided to you. At the time payment in full is received for our services, a Release of the Medical Lien will be immediately provided to you and/or your attorney.

The only time your credit would be affected would be in the event that we receive no payment for our services and we have no alternative but to turn the matter over to a Collection Agency for non-payment after proper notice is given to you. This is rarely an occurrence with motor vehicle accident patients that receive treatment from our clinic.

Spooner Physical Therapy understands that this can be a very difficult period for you and we want to make the process as simple as we can for you. Should you have any questions or concerns, please do not hesitate to let us know. We are here to assist you in every way possible.



**Patient Financial Agreement-Lien
(Equitable Lien-Assignment contract and Indemnification Agreement)**

Patient Name: _____

Please read the following very carefully as it concerns your financial responsibility to the Health Care Provider from whom you are about to receive services.

I the undersigned Patient hereby agree to establish a lien and assignment of benefits or claim in favor of **Spooner Physical Therapy** by this contract and pursuant to any state statues that apply in the state where I reside. I give my permission for **Spooner Physical Therapy** and/or their agent to file, record and serve notice of this agreement (lien/assignment) upon myself and all other parties who may be liable to me for damages arising from the accident which occurred on _____ and any subsequent claims arising from this accident for which I am about to receive health care. I understand that by doing so I have entered into a contract with the above named health care or service provider. This agreement authorizes direct payment to said provider from any and all proceeds from any insurance policy, settlement, judgement verdict or damages to which I may be entitled and paid in connection with the settlement of claims or litigation arising from this accident in such sums necessary to fully compensate the health care or service provider from whom I have received care. This lien and assignment created by this Equitable Lien Contract and Indemnification Agreement shall have priority over any subsequent liens or assignments of my interests.

Patient or Patient Guardian Signature

Date



PAYMENT OPTIONS FOR PERSONAL INJURY CASES

There are potentially several different sources of payment for your rehabilitation expenses due to your personal injury case. We are happy to explain in greater detail if requested. **Please initial ONLY next to the option indicating how you would like Spooner Physical Therapy to bill your account.**

First Party Coverage

If you have auto insurance coverage, including personal injury protection (PIP) or Med Pay, then you have a first party contact between yourself and your insurance carrier. Payments of PIP or Med Pay benefits do not depend on which party is at fault, and cover treatment for injuries for one to three years with limits ranging from \$1,000 to \$25,000, depending on your specific policy. Generally, most insurance carriers will not state policy limits nor divulge what coverage remains, and for that reason Spooner Physical Therapy will file a lien. In most cases this protects the patient as well as Spooner Physical Therapy if the benefits are exceeded. **This not a guarantee of payment for the services rendered and the patient is ultimately responsible for all charges incurred.**

***** I understand that Spooner Physical Therapy will file a lien against me with Maricopa County Recorder's Office, and that a copy will be furnished to me, and/or the third party insurance company, and/or my attorney.
_____ (Initials)

Secondary Coverage

A secondary insurance carrier, such as your health insurance company, can be billed for your treatment. Your carrier will cover a portion of the expenses incurred, leaving the patient responsible for any deductibles, co-insurance, and/or co-payments, and the remainder balance due for Spooner Physical Therapy's customary billed charges. This is known as recoupment and/or subrogation, and at the time of settlement the liable party will reimburse the patient and the insurance carrier for their payments. **Depending on the individual policy, there may be strict limitations on what the health insurance company will cover. Any further balances will be the patient's responsibility. This is not a guarantee of payment for the services rendered and the patient is ultimately responsible for all charges incurred.**

***** I am aware that if I choose to have Spooner Physical Therapy bill my health insurance carrier I will be responsible for all deductibles, co-pays, and co-insurances at the time of service. I am also aware that if I am unable to pay for my deductible, co-pays, and/or co-insurance at the time of service, the amounts will be included in the remainder balance due to Spooner Physical Therapy for customary billed charges. I am also aware that Spooner Physical Therapy will follow my primary health insurance's guidelines, policies, and limitations.

***** I understand that Spooner Physical Therapy will file a lien against me with Maricopa County Recorder's Office, and that a copy will be furnished to me, and/or the third party insurance company, and/or my attorney. _____ (Initials)

Third Party Coverage

This is the coverage of the driver who was at fault. In most cases the third party insurance carrier will not pay any medical related bills until the claim has been settled. In some cases the final settlement check will be sent directly to the patient; the patient is responsible to pay the balance due. We file a lien against the patient and the third party. We will send a copy of the lien once it has been filed to the patient, third party, and your attorney. **A lien is not a guarantee of full payment for the services rendered and the patient is ultimately responsible for all charges incurred.**

***** I understand that Spooner Physical Therapy will file a lien against me with Maricopa County Recorder's Office, and that a copy will be furnished to me, and/or the third party insurance company, and/or my attorney.
_____ (Initials)

I have read and understand all the options available to me:

Patient Signature: _____
Printed Name: _____ Date: _____



Spooner Physical Therapy Injury Information Worksheet

Patient Name: _____ Patient Ph: _____
Address: _____ City: _____ State: _____ Zip Code _____
Date: _____ DOB: _____ DOI: _____
Did Accident occur in Maricopa County? Yes ___ No ___ Were you responsible for Accident? Yes ___ No ___
Did you receive a traffic ticket? Yes ___ No ___ Did the other party receive a traffic ticket? Yes ___ No ___

Health Insurance Primary

Ins Co: _____ Ph # for benefits: _____
Name of Insured: _____
Insured SS #: _____ Insured DOB: _____
Policy #: _____ Group #: _____

Health Insurance Secondary

Ins Co: _____ Ph # for benefits: _____
Name of Insured: _____
Insured SS #: _____ Insured DOB: _____
Policy #: _____ Group #: _____

Med Pay / PIP – (Vehicle patient was in)

Ins Co: _____ Ins Name: _____
Adj name: _____ Claim Open? _____ Limits: _____
Adj Ph #: _____ Fax #: _____
Policy #: _____ Claim #: _____
Claims Address: _____
Lien Filing Address: _____

Third Party / Liability Insurance Company (Insurance for at fault party)

Ins Co: _____ Insured Name: _____
Adj Name: _____ Claim Open? _____
Adj Ph #: _____ Fax #: _____
Policy #: _____ Claim #: _____
Claims Address: _____
Lien Filing Address: _____

Attorney Information

Attorney Name: _____ Contact: _____
Firm Name: _____
Phone : _____ Fax: _____
Address: _____

I authorize Spooner Physical Therapy to contact my attorney, third party, or any other applicable insurance company regarding my accident for billing and/or benefits and/or settlement information.

Patient Signature: _____ Date: _____