



INJURY INFORMATION WORKSHEET

PATIENT INFORMATION

Patient Name _____ Contact Phone _____
Today's Date _____ DOB _____ DOI _____

HEALTH INSURANCE - PRIMARY

Insurance Co. _____
Name of Insured _____ Benefits Phone# _____
Insured SS# _____ Insured DOB _____
Policy # _____ Group # _____

HEALTH INSURANCE - SECONDARY

Insurance Co. _____
Name of Insured _____ Benefits Phone# _____
Insured SS# _____ Insured DOB _____
Policy # _____ Group # _____

MED PAY / PIP - (Vehicle Patient was in)

Insurance Co. _____ Insured Name _____
Adj Name _____ Claim Open? _____ Limits _____
Adj Phone # _____ Fax # _____
Policy # _____ Claim # _____
Claims Address _____ City/ST/Zip _____
Lien Filing Address _____ City/ST/Zip _____

THIRD PARTY / LIABILITY INSURANCE - (Insurance for at fault party)

Insurance Co. _____ Insured Name _____
Adj Name _____ Claim Open? _____
Adj Phone # _____ Fax # _____
Policy # _____ Claim # _____
Claims Address _____ City/ST/Zip _____
Lien Filing Address _____ City/ST/Zip _____

ATTORNEY INFORMATION

Attorney Name _____
Firm Name _____ Contact _____
Phone # _____ Fax # _____
Address _____ City/ST/Zip _____

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

Patient Signature _____ Date _____



DEFERRED PAYMENT CONDITIONS Spooner Physical Therapy

Below is a list of conditions and requirements patients must meet when seeking physical therapy on a deferred payment basis. We understand that this can be a very difficult period and wish to make the process as simple and easy as we can for you. If you have questions please let us know. Please initial each section to show that you have read and understand each condition.

- 1. I understand that **all fees, charges, and bills incurred at Spooner Physical Therapy are ultimately my responsibility.** I understand **it is my responsibility to pay all charges incurred regardless of the outcome of my case against the third party.** _____ *initial*
- 2. I understand that I am responsible for notifying Spooner Physical Therapy if any of my personal information changes (i.e. address, phone numbers, etc.). _____ *initial*
- 3. I understand at the initial visit I am responsible for paying a one-time administrative fee of \$50.00 for the filing of a lien and the releasing of the lien. _____ *initial*
- 4. I understand that **my account balance is due in full two (2) years from the date of injury** or I will be subject to collection proceedings. _____ *initial*
- 5. I understand that Spooner Physical Therapy will send me quarterly letters requesting updates on my case. I understand that I must respond within ten (10) business days or the account balance will be due in full. _____ *initial*
- 6. I understand that Spooner Physical Therapy will charge a yearly interest rate of 10% compounded monthly if my case does not settle within one (1) year of the date of injury. _____ *initial*

Signature of Responsible Party

Date

Printed Name of Patient

*** If payment is made to you directly, your balance will be due in full immediately.**



ACCIDENT/INSURANCE AGREEMENT FOR THIRD PARTY BILLING (Not Billing Health Insurance)

I, _____ am treating with Spooner Physical Therapy due to an injury caused by an accident. The accident date was _____ .

I have instructed Spooner Physical Therapy **NOT** to bill my medical insurance at this time.

I understand that I am ultimately responsible for all charges incurred at Spooner Physical Therapy. I also understand that once Spooner Physical Therapy begins the lien process I will **NOT** be able to go back and have my health insurance billed at a later time.

Patient Name (Printed) _____

Signature of Patient
or Legal Guardian _____

Date _____

* If you receive payment, Spooner Physical Therapy must be reimbursed immediately.



PAYMENT OPTIONS FOR PERSONAL INJURY CASES Spooner Physical Therapy

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 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 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; for this 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 is not a guarantee of payment for the services rendered and the patient is ultimately responsible for all charges incurred.**

*** I am aware that Spooner Physical Therapy may file a lien against me and the third party. I am aware that I am responsible for a \$50.00 administrative fee at my initial visit.

_____ (Initial)

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. This is called subrogation, and at the time of settlement the liable party will reimburse the patient and the insurance carrier. **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 Spooner Physical Therapy will follow my primary health insurance's guidelines, policies, and limitations.

_____ (Initial)

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 health 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. Spooner Physical Therapy will file a lien against the patient and the third party. We will send a certified copy of the lien once it has been filed to the patient, third party, and attorney. **A lien is not a guarantee of payment for the services rendered and the patient is ultimately responsible for all charges incurred.**

*** I agree and understand that Spooner Physical Therapy will file a county lien against the third party. I am aware that a copy will be mailed to me, the third party, and my attorney. I understand and am aware that there is a \$50.00 administrative fee that I am responsible for at my initial visit.

_____ (Initial)

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

Patient Signature _____

Patient Name (Printed) _____ Date _____



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, judgment 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.

In exchange for providing necessary medical care without requiring payment at the time service is received, I agree to be responsible for all charges associated with my care, regardless of the insurance companies' reimbursement. Included are any administrative expenses associated with processing my claim such as charges incurred by the provider for recording and/or servicing notice of this lien/assignment upon any liable parties and their insurance companies. Also included are any collection charges or legal costs and fees incurred by the provider while attempting to collect the medical bills related to this claim if such activity becomes necessary.

I further understand that as part of the process of recording a lien/assignment, I will receive certified mail with a copy of the lien/assignment enclosed, and that this copy is for my own records and does not require any response on my part.

Patient or Guardian Signature

Date