

Alan Kerbs, PT & Associates

AUTO ACCIDENT INFORMATION

Patient:	DOB:	
Insurance Co:		
Address:		
Phone #:	Fax #:	
Adjustor:		
Policy Holder's Name:	;	
Policy #:	Claim #:	
WHEN WE DO	NOT RECEIVE PAYMENT DIRECTLY FROM YOUR <u>COMPANY:</u>	<u>INSURANCE</u>
patient who received of payment for our service you to turn over those them. If we determine the will be provided with w	nter an insurance company which will mail payment for care, rather than directly to us. It is our expectation es from you insurance company, you will contact us important insurance checks to us directly within one week of that you have received payment on our behalf and fail written notice that we expect immediate payment of the services. You will then be given 15 days notice prior exction agency.	n that if you receive mediately. We expect he date you received ed to contact us, you full amount that you
Please sign below that y	ou understand the above policies and agree to the term	ıs above.
Signature	Print Name	Date

Notice: If you have an attorney involved in your case, we need to know immediately to get the appropriate paperwork signed. Please request the Attorney Information Form.

LAYTON PHYSICAL THERAPY & SPORTS MEDICINE, INC

2179 N. 1700 W. Ste. #4 Layton, Utah 84041 (801) 728-4624/ (801) 776-3087

	LIEN	
I authorize and direct my attorney Medicine, Inc. such sums as may be Medicine, Inc. for professional service reason of any other bills that are due withhold such sums from any settle adequately protect Layton Physical Th case to Layton Physical Therapy & Sp settlement, judgment or verdict which or myself as the result of the injuries therewith.	e due and owing Layton Physical es rendered me both by reason of the Layton Physical Therapy & Sports Mement, judgement or verdict as materapy & Sports Medicine, Inc. I further orts Medicine, Inc. against any and a may be paid by any insurance comp	Therapy & Sports as accident and by edicine, Inc. and to by be necessary to er give a lien on my all proceeds of any any to my attorney
I fully understand that I am directly an Medicine, Inc. for all professional bills this agreement is made solely for Layto protection and in consideration for the payment is not contingent on any settles.	s submitted by them for service ren on Physical Therapy & Sports Medicin hem awaiting payment. I further un	dered me and that ne, Inc.'s additional derstand that such
Patient's Signature		Date
The undersigned attorney of record for the above and agrees to withhold somay be necessary to adequately protect	uch sums from any settlement, judg	ment, or verdict as
Attorney's Name (PLEASE PRINT)		
Attorney's Address	City/State	Zip
Attorney's Signature		Date

Please sign, date, and return one copy to Layton Physical Therapy & Sports Medicine, Inc

immediately, and retain a copy for your records. Thank you!