Physical Therapy & Sports Medicine
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 INSURANCE COMPANY:

Occasionally we encounter an insurance company that will mail payment for our services to the patient who received care, rather than directly to us. It is our expectation that if you receive payment for our services from you insurance company, you will contact us immediately. We expect you to turn over those insurance checks to us directly within one week of the date you received them. If we determine that you have received payment on our behalf and failed to contact us, you will be provided with written notice that we expect immediate payment of the full amount that you have received for our services. You will then be given 15 days notice prior to the account being turned over to our collection agency.

Please sign below that you understand the above policies and agree to the terms 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.