Specialized Physical Therapy
Moving You Forward

T: 978-664-4008
F: 866-949-9835
www.specialized-pt.com
161 Main Street STE 3, North Reading, MA 01864

SPT Auto Accident Form – Page 1/2

Welcome to our practice and thank you for choosing Specialized Physical Therapy (**SPT**) for your premium Physical Therapy (**PT**) Services. We are passionate about our practice and committed to providing you and your family with the highest quality of care. We look forward to the opportunity to restore your health to its maximum potential. If you have *any questions or concerns*, please call our clinic and our staff will be happy to assist you.

PRIOR TO BOOKING your first appointment at SPT for an auto accident, we REQUIRE 1) a prescription for PT less than 30 days old, 2) an auto insurance claim number along with your attorney's and adjuster's phone and fax numbers, 3) an authorization/referral for PT for your health insurance from your primary care physician (PCP), and 4) A LETTER OF PROTECTION from your attorney.

Patient Name: _____ Date of Birth: _____

Injuries from Accident: _____

Date of Injury: _____ In this accident, were you the: DRIVER ☐ PASSENGER ☐ PEDESTRIAN ☐

Briefly describe how the accident occurred:

_____

_____

_____

Did you lose consciousness? Yes ☐ No ☐ If yes, how long? _____
Were you wearing a seat belt? Yes ☐ No ☐ Transported by ambulance? Yes ☐ No ☐ Were X-Rays taken? Yes ☐ No ☐
*PIP Insurance application Completed? Yes ☐ No ☐ *Must be completed and submitted before Auto Insurance will pay claims.

Have you ever been in an auto accident before? Yes ☐ No ☐ If yes, what year? _____

Was your vehicle moving at the time of the accident? Yes ☐ No ☐ _____

Are you being advised by an attorney? Yes ☐ No ☐

Name of Attorney: _____

Name of Law Firm: _____

Address: _____

City, State, Zip: _____

Phone Number: _____ Fax: _____

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Automobile Insurance Information

Vehicle #1 (Vehicle you were in at the time of the accident)

Insured's Name: _____

Address: _____

City, State, Zip: _____

Auto Insurance Co: _____

Address: _____

City, State, Zip: _____

Claim Number: _____

Name of Adjuster: _____

Adjuster's Phone Number: _____

Adjuster's Fax Number: _____

Policy Number: _____

Vehicle #2 (Other vehicle involved in accident)

Insured's Name: _____

Address: _____

City, State, Zip: _____

Auto Insurance Co: _____

Address: _____

City, State, Zip: _____

Claim Number: _____

Name of Adjuster: _____

Adjuster's Phone Number: _____

Adjuster's Fax Number: _____

Policy Number: _____

Patient's address matches state driver's license: Yes ☐ No ☐ _____

The patient or parent/legal guardian must provide **ACCURATE, TRUE, COMPLETE, and TIMELY** insurance, billing, third party, and health history information, determine whether our services are covered under your insurance plan, and ensure all insurance, attorney, and third party requirements are met for your plan prior to and throughout treatment. By signing your name on page two of this document and choosing Specialized Physical Therapy, LLC for physical therapy treatment, the patient or parent/legal guardian **certifies** that the *undersigned* **has read, fully understands, and agrees** with all company terms, is ALWAYS primarily liable for any and all unpaid account balances for services rendered, and agrees to pay account balances in full when due; furthermore, if insurance (i.e. health, auto, or workers' compensation) rather than cash is chosen for payment and claims have been fully or partially rejected, denied, or unpaid for **ANY REASON**, the patient or parent/legal guardian agrees to pay IN FULL for services rendered. Policy for patients considered minors (UNDER 18 YEARS OLD): The parent/legal guardian of a patient who is considered a minor is responsible for full payment.

PATIENT NAME (*Print or Type*): _____

PARENT or LEGAL GUARDIAN Name (*Print or Type*): _____

PATIENT or PARENT / LEGAL GUARDIAN **SIGNATURE**: _____ **Date:** _____