Specialized Physical Therapy
Moving You Forward

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

# SPT Auto Accident Form

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. Please note that **you must** complete a **PIP application** in order for claims to be paid by auto insurance. **PIP Application Completed:** Y ☐ N ☐

| | |
|---|---|
| **Adjuster's Name (yours):** | Adjuster's Phone #: |
| Adjuster's Fax for claims: | Auto Insurance Name: |
| Auto Insurance Address: | |
| Auto Claim #: | State of Accident: |
| **Attorney Name (yours):** | Law Firm Name: |
| Attorney Phone #: | Attorney Fax #: |
| Attorney Address: | |
| Were you a pedestrian, cyclist, motorcyclist, auto driver or passenger when struck? | |
| **Adjuster's Name (theirs):** | Adjuster's Phone #: |
| Adjuster's Fax for claims: | Auto Insurance Name: |
| Auto Insurance Address: | |
| Auto Claim #: | Date of Injury: |

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 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:** _____

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# Letter of Protection

Patient's Name: _____ Attorney's Name: _____

Case Number: _____ Date of Injury: _____ State of Injury: _____

I do hereby authorize **Specialized Physical Therapy, LLC** to furnish you, my attorney, with a full report of the examination, diagnosis, treatment, prognosis, etc. of myself regarding the incident in which I was involved.

I further authorize and direct my attorney to pay directly to **Specialized Physical Therapy, LLC**, such sums of monies as may be due and owing to them, (a) for medical services rendered to me for the injury and/or, (b) for any other services, supplies, or reports, and/or (c) legal medical (i.e. impairment rating reports, attorney-physician conferences, and depositions) and to withhold such sums from any settlement or judgment as may be necessary to adequately protect and pay for my treatment in full.

I fully understand that I am directly and fully responsible for all medical bills submitted by **Specialized Physical Therapy, LLC** for services rendered to me and, that this agreement is made solely for said medical provider's additional protection and in consideration of the awaiting payment.

I further understand that such payment is not contingent on any settlement or judgment by which I may eventually recover said fee. I agree that if I change attorneys, that this agreement will remain enforce and effect and that I will notify any subsequent attorney of this agreement and notify **Specialized Physical Therapy, LLC** the name, address, telephone number of my new attorney.

By my signature below, I hereby waive and/or relinquish my right to contest and/or otherwise make any legal objections as to the appropriateness of this agreement and that my attorney has advised me of same. I understand that this agreement shall be governed by the laws of the State of Massachusetts.

Patient's Signature: _____ Date: _____

**ATTORNEY AGREEMENT AND ACCEPTANCE**

The undersigned being the attorney for the above client (patient), does hereby agree to observe all the terms of the above agreement to withhold such sums from any settlement or judgment as may be necessary to adequately protect **Specialized Physical Therapy, LLC** and to promptly pay such sums to them upon receipt of payment of any settlement or judgment without demand. A photocopy of this form shall be considered as valid as the original.

Attorney Signature: _____ Date: _____

ATTORNEY: FAX SIGNED COPY **PRIOR TO** CLIENT'S FIRST APPOINTMENT: **866-949-9835**