Auto Accident/ Personal Injury Information

(Scroll down to page 2 for sample form.)

Doeberling-Muccio
Physical Therapy, Inc.
See what we can do to improve the quality of your life.

Name of Patient: ______________________ DOB: ________

Address: ______________________ City: ________ ST: ____ ZIP: ________

Home Phone: ________ Work Phone: ________ Cell Phone: ________

Sex: ◯ M ◯ F ◯ **Auto Accident** ◯ **Personal Injury**

Date of accident or injury: ______________________

State in which accident or injury occurred: ______________________

Do you have an attorney representing you concerning this accident? ◯ YES ◯ NO

Name of attorney: ______________________ Phone: ________

Address of attorney: ______________________ City: ________ ST: ____ ZIP: ________

It will be your responsibility to notify Doeberling-Muccio Physical Therapy, Inc. with any change of status regarding your account. You must notify us of change of attorney or if you acquire an attorney. Failure to do so could result in your account changing to a delinquent status.

Please be advised that we cannot wait for settlement without a protection letter signed by your attorney and yourself. with a signed protection letter, we will hold your account for 24 months before we attempt to collect from you or obtain legal action on delinquent accounts.

In the event that private health insurance will pay for this service (with prior knowledge of the accident), we request your permission to bill them. Your personal medical insurance cannot be billed after their specified filing time limit.

Beginning November 10, 2010, there will be a $20.00 charge billed directly to the patient for a no-show appointment. This charge will also apply to repetitive cancellations, as determined by D-MPT management.

I hearby understand and agree to the above conditions:

Signature: ______________________ Date: ________

I hearby DECLINE the use of my private health insurance:

Signature: ______________________ Date: ________

(The Ohio Department of Jobs and Family Services is requred by state law to be billed directly regardless of type of injury – traditional Medicaid ONLY!)

☛ ***Note: If you don't have a digital signature, you must sign the form in person before any treatment.***
To learn more about digital signature, click here.

Select location to submit form

Austintown | **Kinsman** | **Niles** | **Warren**

Doeberling-Muccio Physical Therapy, Inc. *Main Office Telephone: 330-399-2221 eMail: info@d-mpt.com Website: www.d-mpt.com*

SAMPLE FORM

Auto Accident/ Personal Injury Information

Name of Patient: Joe Doe DOB: 1-23-1965

Address: 68 Sugarland Drive City: Poland ST: OH ZIP: 44514

Home Phone: 330-100-0000 Work Phone: 330-200-0000 Cell Phone: 330-300-0000

Sex: ◉ M ○ F ◉ **Auto Accident** ○ **Personal Injury**

Date of accident or injury: 1-23-2009

State in which accident or injury occurred: Ohio

Do you have an attorney representing you concerning this accident? ◉ YES ○ NO

Name of attorney: N/A Phone: N/A

Address of attorney: N/A City: N/A ST: N/A ZIP: N/A

It will be your responsibility to notify Doeberling-Muccio Physical Therapy, Inc. with any change of status regarding your account. You must notify us of change of attorney or if you acquire an attorney. Failure to do so could result in your account changing to a delinquent status.

Please be advised that we cannot wait for settlement without a protection letter signed by your attorney and yourself. with a signed protection letter, we will hold your account for 24 months before we attempt to collect from you or obtain legal action on delinquent accounts.

In the event that private health insurance will pay for this service (with prior knowledge of the accident), we request your permission to bill them. Your personal medical insurance cannot be billed after their specified filing time limit.

Beginning November 10, 2010, there will be a $20.00 charge billed directly to the patient for a no-show appointment. This charge will also apply to repetitive cancellations, as determined by D-MPT management.

I hearby understand and agree to the above conditions:

Signature: ______________________ Date: 2-23-2009

I hearby DECLINE the use of my private health insurance:

Signature: ______________________ Date: __________

(The Ohio Department of Jobs and Family Services is requred by state law to be billed directly regardless of type of injury – traditional Medicaid ONLY!)

Select location to submit form

Austintown	Kinsman
Niles	Warren