Advantage Physical Therapy
and Rehabilitation, LLC

Auto Accident/Personal Injury Questionnaire & Agreement

General Information

Patient Name: _____ SS# _____ DOB: _____

What part(s) of your body did you injure? _____

What **DATE** did your injury occur? (BE AS SPECIFIC as possible) _____

WHERE did your accident/injury occur? (BE AS SPECIFIC as possible) _____

_____

Have you retained an attorney? ☐ Yes ☐ No

If YES, please provide us with your attorney's information:

Attorney' s Name:	
Address:	
Telephone:	

Auto Accident

Did your injury arise from an auto accident? ☐ Yes ☐ No

Does anyone else in your home own a car? ☐ Yes ☐ No Do you own any other cars? ☐ Yes ☐ No

Did the police come to the accident? ☐ Yes ☐ No Did the police write a report? ☐ Yes ☐ No ☐ N/A

Do you have a copy of the report? ☐ Yes ☐ No ☐ N/A If **YES**, please provide us with a copy of the report.

Did you receive a ticket for the accident? ☐ Yes ☐ No Did the other driver receive a ticket? ☐ Yes ☐ No

Is the other driver going to say this accident was your fault? ☐ Yes ☐ No

How much property damage was done to your car? $_____

What was the name of the other driver? _____

Please provide us with the names, contact information, and claim numbers of all involved insurance companies:

YOUR Insurance Information		**OTHER PARTY'S** Insurance Information	
Insurance Co:		Insurance Co:	
Address:		Address:	
Telephone:		Telephone:	
Contact Name:		Contact Name:	
Claim No:		Claim No:	

7560 Gardner Park Dr, Gainesville, VA 20155
(703) 753-1005 Phone (703) 753-2207 Fax

9161 Liberia Ave, Ste 205, Manassas, VA 20110
(571) 229-1111 Phone (571) 229-1112 Fax

www.APTRonline.com

Personal Injury

Who do you believe is responsible for your injury? _____

Why do you believe they are responsible for your injury? _____

_____

Did you report this injury to the responsible party? ☐ Yes ☐ No If **YES**, provide the DATE of report: _____

Has fault been determined yet? ☐ Yes ☐ No If **YES**, who was at fault? _____

Please provide us with the names, contact information, and claim numbers of all involved parties and insurance companies:

Responsible Party:	
Address:	
Contact Name:	
Telephone:	
Insurance Company:	
Address:	
Contact Name:	
Telephone:	
Claim No:	

Disclosures & Agreement

Please select **ONE** of the following options:

☐ **Refusal to Waive Health Insurance Benefits**

I have instructed *Advantage Physical Therapy and Rehabilitation, LLC* to file the bill for my injuries sustained in my auto accident or personal injury, which occurred on the date listed above, to my health insurance company or Medicare. However, I understand my therapist will NOT assist in the accident/personal injury case in any manner, other than required by law. Auto accident and personal injury cases require a significant amount of additional work, time and expense. I understand my insurance company will NOT pay the therapist for any of the additional work involved in my case.

Furthermore, most health insurance policies and Medicare contain *Coordination of Benefits* clauses that may delay or preclude your health insurance policy's responsibility to pay your claim. If my health insurance policy denies payment, I agree to abide by *Advantage Physical Therapy and Rehabilitation, LLC*'s Financial Policy, which includes paying for all care at the time of service. As a reminder, HIPAA Privacy Rules (as detailed in our *Notice of Privacy Practices*) permit the disclosure of your medical records for payment purposes.

If I select this option, I understand that the therapist will NOT provide my attorney with any courtesies not legally required, since the clinician will not be compensated for this extra work. *Advantage Physical Therapy and Rehabilitation, LLC* has made it clear that it is ready and willing to submit this claim to my health insurance company or Medicare.

☐ **Waiver of Health Insurance Benefits**

I do hereby waive my health responsibility for all treatment and care arising from my injury, which occurred on the date listed above. I am not filing for health insurance benefits or Medicare benefits and waive their responsibility. The law does not require health care providers to do many of the things that can help prosecute my liability claim. For example, the law does not require therapists to take attorney telephone calls, to meet with attorneys prior to depositions, or provide records and reports not otherwise required by law. These and many other courtesies, which can help my case, take valuable, billable time away from the therapist. I am asking the therapist, of my own free will, to extend these types of courtesies. I understand the therapist may charge for these extra matters. In return, I am agreeing to waive my health benefits, as outlined below. *Advantage Physical Therapy and Rehabilitation, LLC* may act in *complete reliance* upon my waiver in taking actions that they would not otherwise take. The significant benefits I receive from this agreement constitute the consideration necessary to enforce this agreement. These are my wishes.

If I select this option, I understand it is my responsibility to provide a properly executed *Assignment and Authorization* (signed by my attorney and myself). Without, a properly executed *Assignment and Authorization*, I agree to abide *Advantage Physical Therapy and Rehabilitation, LLC*'s Financial Policy, which includes paying for all care at the time of service.

I understand that ALL health insurance companies and Medicare contractually impose limits on the time *Advantage Physical Therapy and Rehabilitation, LLC* has to file a claim. I understand that if my case is ultimately unsuccessful, and my health insurance company's maximum filing limit has lapsed, my outstanding balance for services rendered will be honored according to *Advantage Physical Therapy and Rehabilitation, LLC*'s Financial Policy. I understand that Advantage Physical Therapy and Rehabilitation, LLC WILL NOT file claims to my health insurance company under the above mentioned circumstances. Furthermore, I understand that it is my responsibility to contact my insurance company to determine their specific maximum filing limit.

I agree and understand that I am accepting responsibility to pay for any services rendered herein. I am instructing *Advantage Physical Therapy and Rehabilitation, LLC* **not** to file any claims for benefits with my health insurance plan or Medicare for treatment relating to or arising from the injuries I sustained in this accident. This decision is being made freely and voluntarily by me, without interference or pressure from others, and is made with the understanding of the responsibilities, which arise therefrom.

By signing this document all terms and conditions provided in this document shall be valid and binding upon me for any present or future services provided to me by *Advantage Physical Therapy and Rehabilitation, LLC* for this condition. I also hereby acknowledge receipt of a copy of this document. I understand that I have the right to refuse to sign this agreement and pay for all care at the time of service.

I hereby grant to *Advantage Physical Therapy and Rehabilitation, LLC* and any of its agents a power of attorney to obtain any and all information relating to any insurance claim filed on my behalf, and I authorize the release of any such information to this office.

Furthermore, I acknowledge that this agreement applies only to the services provided by *Advantage Physical Therapy and Rehabilitation, LLC*, and not to any other individuals or facilities, including but not limited to hospitals, anesthesiologists, or other physicians not employed by *Advantage Physical Therapy and Rehabilitation, LLC*.

My decision is being made freely and voluntarily by me, without interference or pressure from others, and is made with the understanding of the responsibilities, which arise therefrom.

If the undersigned is not the Patient, the undersigned represents and warrants that they have full legal authority to sign this document on behalf of the Patient and understands that they are also responsible for all charges incurred due to services, present and future, provided for the Patient's medical condition related to their auto accident or personal injury.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

Copy to Patient By: _____ Date: _____