Motor Vehicle Accident Report

Do you have PIP (Personal injury protection)? Y ☐ N ☐

Name: _____ Date: _____

Date of Accident: _____ Time: _____ Am ☐ Pm ☐

City: _____ Country: _____ State: _____ Location: _____

Describe how Accident Happened: _____

List specific areas of bodily of bodily discomfort resulting from this accident: _____

_____

Have you had same or similar injuries or symptoms prior to accident? Y ☐ N ☐

Were you hospitalized as a result of the accident? ☐ Y ☐ N Where:? _____

Have you been treated by another doctor for injuries sustained in the accident? ☐ Y ☐ N

Other doctors names and dates seen: _____

What treatments or medication have you received for your symptoms or injuries? _____

_____

Have you missed work because of the accident? ☐ Y ☐ N Dates: _____

Were you a ☐ Driver ☐ Passenger ☐ Pedestrian? Were you struck from ☐ Behind ☐ R Side ☐ L Side ☐ Front

Did your car strike other cars(s) involved? ☐ Y ☐ N or Did car(s) strike yours ☐ Y ☐ N ☐ Undetermined

Was a traffic citation issued as a result of the accident? ☐ Y ☐ N To Whom: _____

Who was at fault ☐ Driver of your car ☐ Driver of the other car

Name of insurance company: _____

Claims Office address: _____

Adjuster Name: _____ Adjuster Phone #: _____

Policy #: _____ Claim#: _____

Do you have an attorney? ☐ Y ☐ N Name: _____ Phone#: _____

Complete this Section if other driver was at fault-Action Reaction physical therapy will not bill 3rd party insurance.

Name of at fault driver: _____ Phone#: _____

Address: _____

Insurance company: _____

Claims office address: _____

Adjuster Name: _____ Phone #: _____

Policy #: _____ Claim# _____

I understand that I am financially responsible for all charges and agree to pay for services. I authorize Action Reaction Physical Therapy to release to my insurance company (ies) any and all information necessary to process my claim. I further authorize that payments be made directly to Action Reaction Physical Therapy.

Signature: _____ Date: _____

Notice to MVA Patients

To our Motor Vehicle Accident (MVA) patients-please be advised that Action Reaction Physical Therapy requires the following paperwork from you in order to submit charges on your behalf:

1. Accident Report (Action Reaction PT form) with all information completed on your initial visit.

2. Claim number; claims address (typically not your insurance agent) and PIP adjuster information (name and phone number).

3. Verbal acknowledgment of Personal Injury Coverage (PIP) on your policy and stated current and remaining benefits.

If you claim cannot be processed for any reason please be advised that you will be treated as a self-pay patient and charged at our self-pay rate of $95 per session for all previous physical therapy. If in the future your claim is accepted and we are reimbursed for your dates of service, the $95 out of pocket per session rate will be reimbursed to you.

Please note, it is the patient's responsibility to acquire all information that is needed for billing purposes with Motor Vehicle Accident insurance. It is also the patient's responsibility to follow up with the Motor Vehicle Insurance claims adjuster to make sure the claim is being processed in timely manner to avoid the above stated charge per session. We expect that any changes in the status of your claim be communicated directly to us by our clients.

Please communicate the following examples:

-Insurance company requires an IME (Independent Medical Exam).

-Personal Injury limit has been reached or is about to be exceed the limits on your policy.

-You have engaged an attorney.

Also note, generally MVA insurance cover the billed amount per session. However, there are a few exceptions. Please be aware that Action Reaction PT reserves the right to charge the patient for any remaining balance once the claim has been accepted and paid out.

We appreciate your assistance.

Patient Signature:_____ Date:_____

PATIENT INFORMATION

FIRST NAME:	LAST NAME:	MI:	DATE OF BIRTH:
ADDRESS:	CITY	STATE:	GENDER: ☐ Male ☐ Female
EMAIL:	PHONE NUMBER:	TYPE OF PHONE NUMBER: ☐ Work ☐ Home ☐ Cell	

MARITAL STATUS: ☐ Single ☐ Married ☐ Other	EMPLOYMENT STATUS: ☐ Employed ☐ Student ☐ N/A	EMPLOYER/SCHOOL NAME:	TITLE/POSITION:

HOW DID YOU HEAR ABOUT US?

REFERRING PHYSICIAN INFORMATION:

LAST NAME:	LAST NAME:	PHONE NUMBER:	FAX NUMBER:

CLINIC NAME:

EMERGENCY CONTACT/LEGAL GUARDIAN INFORMATION:

FIRST NAME:	LAST NAME:	DATE OF BIRTH:
PHONE NUMBER:	RELATIONSHIP:	

REASON FOR TODAY'S VISIT:

REASON FOR VISIT:	DATE OF INJURY:	DATE OF ONSET(1st Symptom):

INSURANCE INFORMATION:

PRIMAY INSURANCE COMPANY:	PRIMARY ID #:	PRIMARY GROUP #:
PRIMARY POLICYHOLDER (If other than patient):	PRIMARY POLICY HOLDER DATE OF BIRTH:	
SECONDARY INSURANCE COMPANY	SECONDARY ID#	SECONDARY GROUP #:
SECONDARY POLICY HOLDER (if other than patient)	SECONDARY POLICY HOLDER DATE OF BIRTH:	

INSURANCE ADJUSTER NAME (If applicable)	INSURANCE ADJUSTER PHONE NUMBER (if applicable)

RESPONSIBLE PARTY STATEMENT

As the responsibly party, I agree that all charges are not directly paid by my insurance company will be my responsibility.

Responsibility Party Signature:	Date:

Welcome to Action Reaction Physical Therapy, Inc.!

KNOW YOUR INSURANCE: Your insurance policy is a contract between you and your insurance company. Insurance policies vary, even within the same company. Your insurance company has the final say on what is covered and not covered under your policy. Even though we verify coverage or eligibility for you, ultimately, it is your responsibility to know what your coverage is for services. All questions about your coverage should be directed to your insurance company.

All services you receive here are transactions between you and your health care provider. If the services are not covered by your insurance, you may ultimately be responsible for the cost of these services.

MOTOR VEHICLE INSURANCE: We will bill your open MVA claim. It is recommended that you call your insurance company to verify the amount of coverage and how much is available on your claim. In the event that coverage for services on your plan is for "reasonable and customary," you will be responsible for the amount not paid by the insurance company.

THIRD PARTY INSURANCE: In the event your motor vehicle accident involves third party insurance, you may be charged a $50 lien filing fee. This fee will cover the cost of filing the lien, renewing and releasing the lien once a settlement and payment have been received.

WORKERS COMPENSATION CLAIMS: We will bill your open, approved workers compensation claim. Please be advised that in the event your claim is denied, you are financially responsible for all charges.

PAYMENT OPTIONS: We accept personal checks, debit, cash, Visa, MasterCard and Discover. Insurance co-payments are due at each visit. For all payments made in the clinic, a written receipt will be given to you per request. Any portion of your treatments that are not covered by your insurance becomes your responsibility, and is due within 30 days. Interest may be charged at a rate of 1% per month (12% annually) for unpaid balances over 30 days old. Additionally, a $27.00 fee will be charged to the patient for each incident that a check is returned to us with insufficient funds.

SUPPLIES: We are a non-DME (durable medical equipment) provider and therefore, payment for supplies is due at time of service.

NON-DISCRIMINATION: Admission to our clinic is non-discriminatory for services rendered, regardless of race, color, national origin, disability, or age. All clients who come to our office for services are protected against discrimination assured by the Title VI of the Civil Rights act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

Thank you for allowing us the opportunity to serve you. If you have any questions about the information above or any uncertainty regarding your insurance coverage, please do not hesitate to ask for our assistance.

Patient Signature:_____ Date:_____

Notice of Patient Information Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION. PLEASE REVIEW CAREFULLY.

Action Reaction Physical Therapy, Inc. Legal Duty

Action Reaction Physical Therapy, Inc. is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURE OF HEALTH INFORMATION

Action Reaction Physical Therapy, Inc. uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care provided. For example, Action Reaction Physical Therapy, Inc. may use your personal information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you.

Action Reaction Physical Therapy, Inc. may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, for research studies and for emergencies. We also provide information when required by law.

In any situation, Action reaction Physical Therapy, Inc's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop disclosures at any time.

Action Reaction Physical Therapy, Inc. may change its policy at any time When changes are made, a new Notice of Information Practices will be posted in a common area of our clinic. You may also request an updated copy of our Notice of Information Practices at any time.

Patient's Individual Rights

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request of list of instances where we have disclosed your personal health information for reasons other than treatment, payment or other related administrative purposes.

You may also request in writing that we do not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Action Reaction Physical Therapy, Inc. will consider all such requests on a case-by-case basis, but the Company is not legally required to accept them.

Concerns and Complaints

If you are concerned that Action Reaction Physical Therapy, Inc. may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, you may send a written complaint to the U.S. Department of Health and Human Services or contact the following office:

Action Reaction Physical Therapy, Inc.
2611 NE 125th St, Suite 90
Seattle, WA 98125
(206) 523-6826

Patient Signature: _____ Date: _____

Action Reaction Physical Therapy Cancellation and Missed Appointments Policy

We value your time and hope that you value our time as well. Appointments cancelled less than 24 hours in advance or missed appointments affect our community of patients and physical therapists.

A missed appointment means a physical therapist could not see a patient that might be needing care that day. Therefore, please make note of our cancellation and missed appointment policy below

- You (not your insurance company) will be charged $75.00 for a missed appointment not cancelled at least 24 hours in advance of your scheduled visit
- $$75.00 fee payable upon receipt of invoice
- Exceptions are limited to emergencies

We provide reminder calls the day before your appointment as a courtesy. You are responsible for remembering your scheduled appointment at the time you make the appointment. Stating that you did not receive a reminder call or that the call was made after the 24 hour deadline does not make your missed or cancelled appointment an exception.

By signing the statement below, you are stating that you understand Action Reaction Physical Therapy's cancellation and missed appointment policy.

I, the undersigned have been informed about the Action Reaction Physical Therapy 24 hour cancellation and missed appointment policy. I understand that I will be charged and expected to pay Action Reaction Physical Therapy $75.00 for appointments not cancelled at least 24 hours in advance, or for any missed appointments.

I have been informed that reminder calls are made the day prior to my appointment as a courtesy, but that I am expected to remember my appointment at the time I make that appointment. (Reminder calls are often made less than 24 hours before the scheduled appointment time.)

Patient Signature:_____ Date:_____

I opt out of receiving reminder phone calls: ☐

I'd rather receive email reminders: ☐ email address: _____

ASSIGNMENT OF BENEFITS/AUTHORIZATION TO RELEASE MEDICAL INFORMATION/CONSENT TO TREAT

I hereby assign all medical benefits to which I am entitled to Action Reaction Physical Therapy in the event they file insurance on my behalf. I understand that I am financially responsible for all charges whether or not paid by said insurance. In the event my account becomes delinquent and is therefore in default of payment, I accept responsibility for the principal amount owing as well as all reasonable costs associated with the collection of this debt. This includes but is not limited to collection service fees, attorney's fees, and all court costs and additional legal fees associated with the recovery of this debt. Interest may be charged at a rate of 1% per month (12% annually) for unpaid balances over thirty days old. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits. A copy of this assignment shall be considered as effective and valid as the original. I do hereby consent to such treatment by the authorized personnel of Action Reaction Physical Therapy and may be dictated by prudent medical practice by my illness, injury, or condition. This consent is intended as a waiver of liability for such treatment except acts of negligence.

Signature:_____ Date:_____

Patient History

Name: _____ Male: ☐ Female: ☐ Date: _____

Age: _____ Height: _____ Weight: _____ Occupation: _____

Area of injury/Symptoms: _____ Date symptoms/injury started: _____

How did your symptoms start? _____

Diagnosis from your doctor: _____ Date of your next doctor recheck: _____

Are you off work because of the problem? ☐ No ☐ Yes; If yes last day worked: _____

How would you describe your problem? _____

_____

Using the Diagram, indicate the specific area of pain. If your pain travels draw arrows

Please RATE your pain level: No Pain ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 Worst Pain

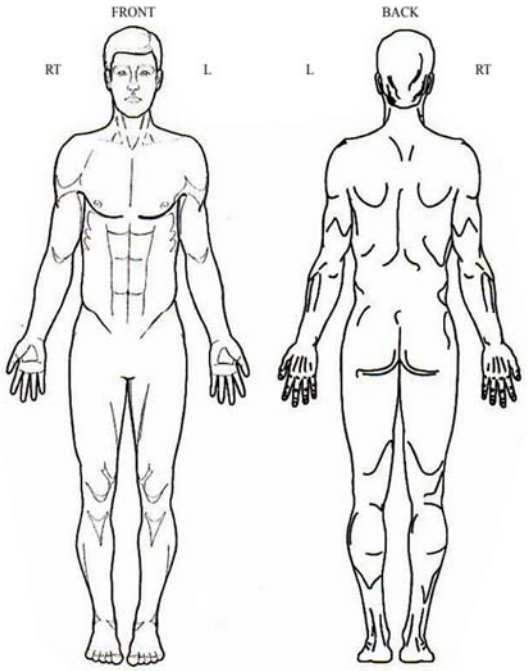
How would you Describe your pain:

☐ Dull ache ☐ Burning ☐ Heavy ☐ Sore

☐ Deep ache ☐ Throbbing ☐ Twinge ☐ Other: _____

☐ Stabbing ☐ Squeezing ☐ Cramp

☐ Nagging ☐ Drawing ☐ Sharp



What eases the Pain?

_____

_____

What Aggravates the Pain?

_____

_____

Have you had any other treatments for this problem? ☐ No ☐ Yes; What types? _____

_____

If female are you pregnant? ☐ Yes ☐ No

Have you had x-rays? ☐ Yes ☐ No

Please list any tests you have received and the results:

_____

_____

Past Medical History

Have you ever been diagnosed with any of the following conditions?

- ☐ Cancer
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Asthma
- ☐ Emphysema
- ☐ Chemical Dependency (Alcoholism)
- ☐ Thyroid Problems
- ☐ Diabetes
- ☐ Multiple Sclerosis
- ☐ Rheumatoid Arthritis
- ☐ Other Arthritic problems
- ☐ Depression
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Stroke
- ☐ Kidney Disease
- ☐ Anemia
- ☐ Epilepsy
- ☐ Insomnia
- ☐ Constipation/Diarrhea
- ☐ Other: _____

Please list any SURGERIES or other conditions for which you have been hospitalized, including the approximate date and reason for surgery or hospitalization:

_____

_____

Please describe any INJURIES for which you have been treated (including fractures, dislocations, sprain, etc.) and the approximate date of injury.

_____

_____

Please describe your normal activity level:

How often do you exercise?

- ☐ Daily
- ☐ 3-4 days per week
- ☐ 1-2 Days per week
- ☐ Less than once per week
- ☐ Not At All

What Exercise do you do?

- ☐ Walk
- ☐ Run/jog
- ☐ Swim
- ☐ Bike
- ☐ Other: _____
- ☐ Gym Exercise
- ☐ Tennis
- ☐ Golf
- ☐ Yoga/Pilates

Please list all medications that you are currently taking(includes herbal supplements and over the counter drugs):

_____

_____

What are your personal goals for therapy?

_____

_____