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:_____________________