We need ALL of the information listed to bill for your therapy visits.
Please complete ALL of this form.

Auto Accident Information Sheet

It is the patient's responsibility to gather this information and return it to Wasatch Peak Physical Therapy within 4 days from the date of service.

If this form is not returned to Wasatch Peak, the patient will be responsible for all charges. If there are unusual circumstances please contact Wasatch Peak so arrangements can be made. Thank you.

If you have any questions please contact our admitting personnel at Wasatch Peak Physical Therapy at 825-8091. Thank you.

Patient Name ______________________ DOB ____________

Patient Home Address ______________________________

City ______________ State ________ Zip ____________

Home Telephone Number ( ) ______________________

Name of Insurance ______________________________

Address to Send the Claims to ______________________

____

City ______________ State ________ Zip ____________

Contact Person ______________________________

Contact Person's Phone Number ______________________

Date of Accident ______________________________

Claim Number ______________________________

We realize the above insurance information is in regards to an auto accident claim. However, if the above entity denies your claim, we will need to have your personal health insurance to bill. Still, some personal health insurances require we have prior authorization for your therapy visits. Therefore, if you choose not to give us your personal health insurance at this time, and the above listed entity denies payment, and your personal health insurance requires prior authorization that we were unable to receive, you will be responsible for payment. To avoid any problems, please give your personal health insurance information along with the above information. By signing below, you indicate that you understand this information. Thank you.

Patient Signature ______________________________ Date __________