

Motor Vehicle Accident - MedPay Insurance Information

We **only** accept Medical Payments, also called Medpay (and sometimes called Personal Injury Protection, or PIP, depending on the state or policy). We do not bill third-party claims.

The following information is based on YOUR auto insurance policy (or the person's vehicle you were in)-- not the other driver/at-fault driver's policy.

If you do not have Medical Payments (Medpay) or PIP on your policy then you have the option of paying out of pocket at the time of service and submitting for reimbursement yourself. We offer a **pay-at-time-of-service discount**, as well as **pre-paid packages** that include a discount. Please ask the front desk for more details.

If you will be paying yourself, then please fill out the "Motor Vehicle Accident Claim - Self Pay - Pay at Time of Service" form instead of this one. Thank you.

Your Auto Insurance Information (we will collect the other driver's info in the next section)

1. **Your** Insurance Company Name: _____
2. Do you have Medical Payments (MedPay) on your policy? Yes _____ No _____
3. Do you have Personal Injury Protection (PIP) on your policy (usually an out of state policy)?
Yes _____ No _____
4. **Claim Number:** _____
5. Patient's full name _____
6. Patient's date of birth: _____
7. Date of Injury/Accident: _____
8. What county was your accident in? PIMA / MARICOPA / ETC/ _____
9. What state was the accident in? _____
10. Are you the policy holder? YES / NO If not, who is? _____
 - a. What is your relationship to the policyholder? _____
 - b. Policy holder's address and phone number: _____

11. Is the policy an Arizona policy? YES / NO If not, which state is the policy under? _____
12. Policy Number: _____
13. Medical Adjuster's Name: _____
14. Medical Adjuster's Phone Number: _____
15. Medical Adjuster's Fax Number: _____
16. Medical Adjuster's Email: _____
17. Insurance Company Billing Address: _____
18. What is your Medpay or PIP coverage amount? \$ _____
19. Has your MedPay/PIP already been exhausted? _____
20. Did you go to the Emergency Room? _____ Did they bill your Medpay policy? _____
21. Were you transported via Ambulance? _____ Did they bill your Medpay? _____
22. Have you seen any other medical providers due to this accident? _____
23. If yes, who are you seeing or have you seen? _____
24. Did they/are they billing your Medpay policy? _____

The Other Driver's Insurance Information

This is information required to fill out the CMS1500 Billing Form used by all healthcare providers in the United States when billing an insurance carrier. This information may also be used to file a medical lien.

1. Insurance Company Name: _____
2. Other Driver's Name (or their insured party) _____
3. Insurance Company Address _____
4. Claim Number: _____
5. Adjuster's Name: _____
6. Adjuster's Phone Number: _____
7. Did they claim being "At-Fault"? _____
8. Are you considered "At-Fault"? _____

Your Attorney Information (if you do NOT have an attorney, you agree to notify us immediately if/when one is obtained)

1. Do you have an attorney to represent you in this case? _____
2. If so, what is their name? _____
3. What firm do they work for _____
4. Attorney Phone: _____
5. Attorney Address: _____
6. Attorney Email: _____

Consent to Bill / Financial Responsibility

I acknowledge and agree to allow Miller Medical Massage (also referred to as MMM) to bill my insurance company and/or any third party insurance company or my attorney for services provided to me by Miller Medical Massage. I understand a lien may be filed on my case, regardless if I have MedPay/PIP or not. I understand that MMM only accepts cases where the patient has Medical Payments or Personal Injury Protection on their policy or the policy of the owner's car they were in when the collision occurred, or when the patient is paying out of pocket at the time of service.

I understand that I am responsible for all bills incurred at MMM that are not paid by any insurance company, settlement or attorney. I understand that my medical bills are my responsibility and agree to pay them if the insurance company/companies/attorney does not pay them. MMM does not reduce their fees under any circumstance.

I also understand that MMM cannot bill my MedPay or PIP for missed or late-cancel appointments. Those costs are my responsibility and due at the next appointment before services are rendered. The cost for a missed or late-cancel appointment is the **FULL COST** of the scheduled appointment. This fee will be due immediately and required to be paid before the next appointment. I understand that any fees that are due, will be charged to my credit/debit card on file or removed from any pre-paid package I may have.

Medical massage treatment costs can vary depending on the treatment provided, duration, etc. I understand that I am able to ask the front desk what the charges for my visits are at any time and MMM will provide me with that information.

Signature _____ **Date:** _____

Print Name _____ **Date:** _____

Policy for Motor Vehicle Accident Cases

Medical Payments (MedPay)

I understand that Miller Medical Massage (MMM) only treats motor vehicle accident (MVA) patients who have Medical Payments (MedPay) or Personal Injury Protection (PIP) on their auto insurance policy, or on the policy of the car they were in when the accident occurred, or patients who are paying out of pocket at the time of service.

Initial Here _____

MMM does not bill the at-fault driver's insurance or the other driver's insurance. These are considered third-party claims and MMM does not accept these types of claims as they can sometimes take years to settle and MMM is left unpaid during that time.

Initial Here _____

I understand that I have the option to pay out of pocket at the time of service and that MMM will provide me with Superbills and receipts upon request, which I can then submit to insurance for reimbursement. I understand that there is a discounted price for paying at the time of service and/or purchasing a prepaid package.

Initial Here _____

Third Party Cases (this means the patient does not have MedPay or PIP)

Miller Medical Massage does not currently accept any third-party claims. MMM only accepts claims that have an open Medpay or PIP claim or cases where the patient wants to pay out of pocket at the time of service.

Initial Here _____

Health Insurance

Miller Medical Massage does **not** bill health insurance for my auto injury case. Part of the reason for this is that MMM has yet to find an insurance carrier or policy in Arizona that covers Massage Therapy. Many other states have health insurance that covers massage, however, at this time, Arizona coverage seems to be limited in this regard. MMM does **not** bill out of state health insurance plans either.

I understand that even if my health insurance plan does cover massage, that MMM will **not** bill my health insurance plan directly. MMM will furnish me with any Superbills or receipts I request. I understand I would still be responsible for submitting my own claim reimbursement forms, on my own, without the assistance of MMM-- should I choose to go this route.

Initial Here _____

Your Name _____ Date _____

Signature _____

Agreement for Direct Payment of Funds

The majority of this agreement is directed at patients who currently have an attorney. If you do not currently have an attorney, then signing this agreement will be in place for if/when you do obtain one.

If you have an attorney, or should you obtain one during the open injury claim we are treating you for, the following agreement is required to be followed by every patient seen at Miller Medical Massage (also referred to as, "MMM") under an Auto Insurance Claim. Please be mindful of these policies, make sure that you understand them and ask any questions you have before signing this document.

1. If you obtain an attorney or change your attorney or law firm during the course of your treatment, you agree to notify MMM of your new attorney, and/or law firm immediately upon doing so. **Initial Here** _____

2. In the event that your attorney directs your insurance carrier to send them (your attorney) your Medpay funds instead of paying the providers directly, this signed document is requesting your attorney pay MMM directly from your Medical Payments (Medpay) Funds immediately upon receipt of any bill received by MMM. **Initial Here** _____

3. In the event your attorney has requested your insurance carrier retain your Medpay funds and NOT pay any bills provided to them, you are consenting to and requesting that your attorney contact the carrier and give them the authority to pay MMM directly, even if other providers are not allowed to be paid from that money. **Initial Here** _____

4. MMM is unable to wait for payment beyond the 30 days allowed by law when we normally bill your Medpay policy. This is stated in our policies. We do not accept Third-Party cases and we do not wait until settlement for payment. Please initial here stating that you understand this policy, and that you request your attorney pay us directly and immediately and authorize these payments to us at MMM. **Initial Here** _____

5. You are giving us permission to request this from your attorney, should the need arise, with your consent and you are requesting your attorney to abide by this policy/agreement and pay us directly and promptly. **Initial Here** _____

6. If you or your attorney, at any time, decide not to abide by this agreement our office has, then you, the patient, will immediately owe the total balance owed and we will no longer wait for payment, as we would if billing your Medpay policy (30 days). In addition, any future treatments in our office will require payment in full at the time of service. **Initial Here** _____

7. If you rescind this agreement at any time you agree to your credit/debit card on file being charged for the total balance owed, immediately upon revocation of this agreement. **Initial Here** _____

8. A medical lien may be filed in my case, to ensure proper payment to MMM. **Initial Here** _____

Your Name _____ **Date** _____

Signature _____