Self Pay - Motor Vehicle Accident Claim Information

If you are paying out of pocket for an auto injury, and would like your claim details attached to your care here in our office, please fill out the following information. **If you choose NOT to fill out this form then please CROSS OUT THE WHOLE PAGE and Sign Your Name at the Bottom.**

INSURANCE CLAIM DETAILS

Patient's full name: _____

Your insurance company name: _____

Claim number with YOUR insurance company: _____

Other driver's insurance company name: _____

Claim number with OTHER DRIVER's insurance Co.: _____

Date of Injury/Accident: _____

What county was your accident in? PIMA / MARICOPA / OTHER: _____

What state was your accident in _____

ATTORNEY INFORMATION

Your Attorney's Contact Information (If you don't have an attorney, please check here ____)

Name of attorney: _____

Phone: _____Fax: _____

Email:_____

Address: _____

If you obtain an attorney at any point, or if your attorney changes, you agree to notify us right away so that we may update your file and make any adjustments necessary. **Initial here** _____

Name _____ Date _____

Signature_____

Please Provide us With a Copy of Your Referral for Massage / Manual Therapy

(office staff: attach copy of referral to this page)

Information that must be included on your referral, should you choose to provide us with one (highly recommended).

- Name of Referring Healthcare Provider
- Address
- Phone
- Provider's NPI Number
- Diagnostic Codes
- Frequency and Duration recommended by this provider? and/or
- Total number of sessions recommended by this provider?

Office Use:

_____Referral Received and Attached to This Page

_____Referral Being Sent by Provider By (date): _____

_____Patient Declines to Provide Referral