

Auto Accident/ Personal Injury Information

(Scroll down to page 2 for sample form.)



Doeberling-Muccio
Physical Therapy, Inc.

See what we can do to improve the quality of your life.

Name of Patient: _____ DOB: _____

Address: _____ City: _____ ST: _____ ZIP: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Sex: M F **Auto Accident** **Personal Injury**

Date of accident or injury: _____

State in which accident or injury occurred: _____

Do you have an attorney representing you concerning this accident? YES NO

Name of attorney: _____ Phone: _____

Address of attorney: _____ City: _____ ST: _____ ZIP: _____

It will be your responsibility to notify Doeberling-Muccio Physical Therapy, Inc. with any change of status regarding your account. You must notify us of change of attorney or if you acquire an attorney. Failure to do so could result in your account changing to a delinquent status.

In the event that private health insurance will pay for this service (with prior knowledge of the accident), we request your permission to bill them. Your personal medical insurance cannot be billed after their specified filing time limit.

Beginning November 10, 2010, there will be a \$20.00 charge billed directly to the patient for a no-show appointment. This charge will also apply to repetitive cancellations, as determined by D-MPT management.

I hereby understand and agree to the above conditions:

Signature: _____ Date: _____

I hereby DECLINE the use of my private health insurance:

Signature: _____ Date: _____

(The Ohio Department of Jobs and Family Services is required by state law to be billed directly regardless of type of injury – traditional Medicaid ONLY!)

 **Note: If you don't have a digital signature, you must sign the form in person before any treatment.**
To learn more about digital signature, [click here](#).

Select location to submit form

Austintown

Kinsman

Niles

Warren

Auto Accident/ Personal Injury Information



Name of Patient: Joe Doe DOB: 1-23-1965

Address: 68 Sugarland Drive City: Poland ST: OH ZIP: 44514

Home Phone: 330-100-0000 Work Phone: 330-200-0000 Cell Phone: 330-300-0000

Sex: M F **Auto Accident** **Personal Injury**

Date of accident or injury: 1-23-2009

State in which accident or injury occurred: Ohio

Do you have an attorney representing you concerning this accident? YES NO

Name of attorney: N/A Phone: N/A

Address of attorney: N/A City: N/A ST: N/A ZIP: N/A

It will be your responsibility to notify Doeberling-Muccio Physical Therapy, Inc. with any change of status regarding your account. You must notify us of change of attorney or if you acquire an attorney. Failure to do so could result in your account changing to a delinquent status.

In the event that private health insurance will pay for this service (with prior knowledge of the accident), we request your permission to bill them. Your personal medical insurance cannot be billed after their specified filing time limit.

Beginning November 10, 2010, there will be a \$20.00 charge billed directly to the patient for a no-show appointment. This charge will also apply to repetitive cancellations, as determined by D-MPT management.


I hereby understand and agree to the above conditions:

Signature: _____ Date: 2-23-2009

I hereby DECLINE the use of my private health insurance:

Signature: _____ Date: _____

(The Ohio Department of Jobs and Family Services is required by state law to be billed directly regardless of type of injury – traditional Medicaid ONLY!)

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