HOLLAND PHYSICAL THERAPY

Date: _____

Patient Name: _____Med Rec # / Account#_____

ADDITIONAL LIABILITY INFORMATION

The nature of your injury may alert your medical insurance company to potential liability. Completing this form in its entirety allows ***Provider*** to provide a quick response to those inquiries and prevent delays in processing your claims.

Date of injury/onset of condition / recent exacerbation? _____

Describe in detail how injury occurred. _____

_____

Specific name & location where injury occurred (IE: store, restaurant, intersection, etc.)

_____

_____

Is this injury work related? Yes_____ No_____

Who is responsible for accident? Self:_____ Other: _____

If other, who? _____

Insurance of responsible party: Name: _____
Address: _____
_____
Claim #: _____
Adjuster Name: _____
Adjuster Phone: _____

Personal insurance: Name:_____
Address: _____
_____
Claim #: _____
Contact Name:_____
Contact Phone:_____

The above information is accurate and true to the best of my knowledge. I agree to immediately notify provider with any change in this information.

Patient's Signature: _____ Date: _____

Print Name:_____(**when patient is a minor, or is not competent to give consent, the signature of a parent, guardian, or other legal representative is required).**

Signature of Legal Representative: _____Date: _____

Print Name of Legal Representative: _____

Description of Legal Representative Authority: □ Parent □ Medical Power of Attorney (attach documentation)

□ Other _____ (Explain and Attach Documentation)
