CLEAR FORM

Welcome to Spooner Physical Therapy! We understand that you have been injured in a motor vehicle accident or other 3rd party responsible personal injury situation. It is our goal at Spooner Physical Therapy to:

- Prevent further injury and/or loss of movement
- Reduce your level of pain and improve your ability to move
- Restore your functional ability

These documents outline the handling of financial responsibility resulting from your accident and are intended to assist you in every way possible to understand your options with regard to payment for your treatment, and how it relates to the settlement of your case.

If you have already retained an attorney in this matter, Spooner Physical Therapy will work with your attorney to obtain the best possible settlement in your case.

Did the motor vehicle accident in which you were injured or personal injury occur in Maricopa County?

○ Yes ○ No

Every state has its own statutes or laws, and the State of Arizona allows you options regarding medical bill payment for your motor vehicle accident. Arizona Statutes allow all medical treatment to be billed at the facility's usual and customary rates.

Spooner Physical Therapy allows you to choose from the following forms of payment of your therapy bill:

- **Your automobile insurance**, also known as Med Pay or PIP (Personal Injury Insurance) or UIM (Under-Insured Motorist Insurance). You will NOT be penalized for using your own automobile insurance for payment of your medical bills. Normal limits range from $1,000 to $25,000 per person. You can verify the total amount of your Med Pay Coverage by checking the "Declarations Page" furnished to you by your insurance company under "Coverage & Limits" or calling your agent. *Please provide this information to our front office staff if you choose this option. We are not able to access your personal automobile policy information.*

- **Third party automobile insurance** (the automobile insurance company of the party who caused the accident and your injuries).

- **Your health insurance**, with the exclusion of government funded medical programs ie. Medicare, AHCCCS, Tricare. If you are covered by one of these programs, you must use your automobile insurance, third party automobile insurance or file a lien.

You can designate which of the above plans you wish us to bill on your behalf. You have the option of choosing more than one; i.e., bill third party automobile insurance first, and upon the exhaustion of those benefits, bill your health insurance.

In order for us to receive payment for our skilled services, **we are required by Arizona law** to file a lien with the Maricopa County Recorder's Office, and to notify you, your attorney if you have retained one, and the automobile insurance company of the third party (the party's automobile insurance of the person who caused the accident) that we have provided medical treatment to you.

This lien **WILL NOT affect your credit** unless we do not receive payment for our medical services. It is merely a requirement of the State of Arizona to assure that we, as your medical provider, will be paid in full for our services provided to you. At the time payment in full is received for our services, a Release of the Medical Lien will be immediately provided to you and/or your attorney.

> In the case that we do not receive payment for our services, your credit could be affected if we have no alternative but to turn the matter over to a collection agency after proper notice is given to you. This is an extremely rare occurrence with motor vehicle accident patients that receive treatment at one of our locations.

Spooner Physical Therapy understands that this can be a very difficult period for you and we want to make the process as simple as we can for you. Please notify our front office staff should you have any questions or concerns, please do not hesitate to let us know. Our focus is your full recovery!

Patient Financial Agreement-Lien
(Equitable Lien-Assignment contract and Indemnification Agreement)

Patient Name: _____

Please read the following very carefully as it concerns your financial responsibility to the Health Care Provider from whom you are about to receive services.

I the undersigned Patient hereby agree to establish a lien and assignment of benefits or claim in favor of **Spooner Physical Therapy** by this contract and pursuant to any state statues that apply in the state where I reside. I give my permission for **Spooner Physical Therapy** and/or their agent to file, record and serve notice of this agreement (lien/assignment) upon myself and all other parties who may be liable to me for damages arising from the accident which occurred on _____ and any subsequent claims arising from this accident for which I am about to receive health care. I understand that by doing so I have entered into a contract with the above named health care or service provider. This agreement authorizes direct payment to said provider from any and all proceeds from any insurance policy, settlement, judgment verdict or damages to which I may be entitled and paid in connection with the settlement of claims or litigation arising from this accident in such sums necessary to fully compensate the health care or service provider from whom I have received care. This lien and assignment created by this Equitable Lien Contract and Indemnification Agreement shall have priority over any subsequent liens or assignments of my interests.

_____ _____
Patient or Patient Guardian Signature Date

PAYMENT OPTIONS FOR PERSONAL INJURY CASES

Please select and initial ONLY the options indicating how you would like Spooner Physical Therapy to bill your account.

Your automobile insurance: □ Primary □ Secondary □ Tertiary

If you have auto insurance coverage, including personal injury protection (PIP) or Med Pay, then you have a first party contact between yourself and your insurance carrier. Payments of PIP or Med Pay benefits do not depend on which party is at fault, and cover treatment for injuries for one to three years with limits ranging from $1,000 to $25,000, depending on your specific policy. Generally, most insurance carriers will not state policy limits nor divulge what coverage remains, and for that reason Spooner Physical Therapy will file a lien. In most cases this protects the patient as well as Spooner Physical Therapy if the benefits are exceeded. **This not a guarantee of payment for the services rendered and the patient is ultimately responsible for all charges incurred.**

***** I understand that Spooner Physical Therapy will file a lien with Maricopa County Recorder's Office, and that a copy will be furnished to me, my attorney, and the third/responsible party insurance company.
_____ (Initials)

Third party automobile insurance: □ Primary □ Secondary □ Tertiary

This is the coverage of the driver who was at fault. In most cases the third party insurance carrier will not pay any medical related bills until the claim has been settled. In some cases the final settlement check will be sent directly to the patient; the patient is responsible to pay the balance due. We file a lien against the patient and the third party. We will send a copy of the lien once it has been filed to the patient, third party, and your attorney. **A lien is not a guarantee of full payment for the services rendered and the patient is ultimately responsible for all charges incurred.**

***** I understand that Spooner Physical Therapy will file a lien with Maricopa County Recorder's Office, and that a copy will be furnished to me, my attorney, and the third/responsible party insurance company.
_____ (Initials)

Your health insurance: □ Primary □ Secondary □ Tertiary

Your health insurance company can be billed for your treatment, unless it is a government funded program such as Medicare, Medicaid/AHCCCS, or Tricare. Your carrier will cover a portion of the expenses incurred, leaving the patient responsible for any deductibles, co-insurance, and/or co-payments, and the remainder balance due for Spooner Physical Therapy's customary billed charges. This is known as recoupment or subrogation, and at the time of settlement the liable party will reimburse the patient and the insurance carrier for their payments. Depending on the individual policy, there may be strict limitations on what the health insurance company will cover. **Any further balances will be the patient's responsibility. This is not a guarantee of payment for the services rendered and the patient is ultimately responsible for all charges incurred.**

***** I am aware that if I choose to have Spooner Physical Therapy bill my health insurance carrier I will be responsible for all deductibles, co-pays, and co-insurances at the time of service. I am also aware that if I am unable to pay for my deductible, co-pays, and/or co-insurance at the time of service, the amounts will be included in the remainder balance due to Spooner Physical Therapy for customary billed charges. I am also aware that Spooner Physical Therapy will follow my primary health insurance's guidelines, policies, and limitations.

***** I understand that Spooner Physical Therapy will file a lien against me with Maricopa County Recorder's Office, and that a copy will be furnished to me, my attorney, and the third/responsible party insurance company.
_____ (Initials)

I have read and understand all the options available to me:

Patient Signature: _____
Printed Name: _____ Date _____

CLEAR FORM

Spooner Physical Therapy Personal Injury Information Worksheet

Patient Name: _____ Phone #:_____
Address: _____ City: _____ State:_____ Zip Code:_____
Date: _____ DOB:_____DOI: _____
Did Accident occur in Maricopa County? Yes ☐ No ☐ Were you responsible for Accident? Yes ☐ No ☐
Did you receive a traffic ticket? Yes ☐ No ☐ Did the other party receive a traffic ticket? Yes ☐ No ☐

Your automobile insurance - Med Pay / PIP

Ins Co: _____ Ins Name: _____
Adj name: _____ Claim Open? _____Limits:_____
Adj Ph #: _____ Fax #: _____
Policy #: _____Claim #:_____
Claims Address: _____
Lien Filing Address: _____

Third party automobile insurance - (Insurance for at fault party)

Ins Co: _____ Insured Name: _____
Adj Name:_____ Claim Open? _____
Adj Ph #:_____Fax #: _____
Policy #: _____Claim #:_____
Claims Address: _____
Lien Filing Address: _____

Your health insurance – primary coverage

Ins Co: _____ Ph # for benefits:_____
Name of Insured: _____
Insured SS #: _____Insured DOB: _____
Policy #:_____Group #:_____

Your health Insurance - secondary

Ins Co: _____ Ph # for benefits: _____
Name of Insured: _____
Insured SS #: _____Insured DOB: _____
Policy #:_____Group #:_____

Attorney Information

Attorney Name: _____Contact:_____
Firm Name: _____
Phone : _____Fax:_____
Address: _____

I authorize Spooner Physical Therapy to contact my attorney, third party, or any other applicable insurance company regarding my accident for billing, benefits and settlement information.

Patient Signature: _____ Date:_____