MOTOR VEHICLE ACCIDENT AND/OR WORKER'S COMPENSATION INFORMATION

Motor Vehicle Accident/Personal Injury (if applicable)

>Date of Accident: ____/____/_____ **What State did the accident occur in:** _____
>Have you reported the accident to your auto insurance company? ○Y ○N
>If yes when? ____/____/_____ Have you filed a PIP or NO FAULT application with your auto insurance carrier? ○Y ○N
>Do you have an open or pending case with them? ○Y ○N
>Were you the driver of the vehicle you were in? ○Y ○N
>Was the vehicle you were in at fault? ○Y ○N
>Have you received any other medical treatment for injuries related to this accident? ○Y ○N

Your Auto Insurance Carrier's Name: _____ Policy #_____

Claim Number# _____

Adjuster's Name: _____ Phone # _____

3rd Party Auto Insurance Carrier's Name: _____ Policy #_____

Claim Number# _____

Adjuster's Name: _____ Phone #_____

Do you have an attorney? ○Y ○N If yes, Name and phone # _____

If no, would you like for us to recommend one? ○Y ○N

Worker's Compensation (if applicable)

Date of Injury: ____/____/_____ **State the accident occurred in:** _____

Have you or your employer filed a claim? ○Y ○N If yes, When? ____/_____/_____

Is your case open/pending? ○Y ○N Name of Physician who Referred you for Chiro/PT : _____

Worker's Comp Insurance Carrier Name _____ Phone # _____

Claim #: _____ Adjuster's Name _____ Phone #_____

Do you have an attorney? ○Y ○N If yes, name and phone # _____
If no, would you like for us to recommend one? ○Y ○N

By signing below I confirm that the information provided above is true to the best of my knowledge. I understand that I may be billed administrative and filling fees for withholding information as it relates to my medical history or insurance coverage.

I understand that Sport and Spine Rehab will submit claims on my behalf to the appropriate insurance carriers using the information I have given them. I am aware that it if my treatment is related to an auto accident or work comp injury it is my responsibility to also adhere to the guidelines of my Major Medical insurance so that in the event my personal injury case closes, my health insurance will be billed and I will be responsible for any co- payments, deductibles or non-covered services.

Print Name_____ **Signature**_____ **Date** _____
(Parent/Guardian if patient is a minor)

Witness Signature _____ **Date**_____

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Wintergreen Plaza
827 E Rockville Pike
Rockville, MD 20852
301.251.2777

Sport and Spine Rehab of McLean
6845 Elm Street, Ste 425
McLean, VA 22101
703.448.5799

Metro Sport and Spine Rehab
Metro 400 Building
4301 Garden City Drive, Ste 104
Landover, MD 20785
301.577.1115

Sport and Spine Rehab of Columbia
Hickory Plaza
10805 Hickory Ridge Road, Ste 103
Columbia, MD 21044
410.964.0837

Sport & Spine Rehab of Ft Washington
9300 Livingston Road
Fort Washington, MD 20744
301.203.6734

Sport and Spine Rehab of Fairfax
3925 Chain Bridge Road, Suite 101
Fairfax, VA 22030
703-890-2222

Sport and Spine Rehab of Sterling
46440 Benedict Dr, Suite 106
Sterling, VA 20164
571-323-2120