



In Motion Therapy™

Auto/Workers Comp Patient Registration Form

Name _____ DOB _____ Acct # _____

(Please Circle One) Auto or Worker Comp

Insurance Company _____ Claim# _____

Claims Mailing Address _____

City _____ State _____ Zip _____

Date of Injury _____ Place of Injury _____

Current Employer _____ Occupation _____

Claim Representative Name _____

Claim Representative Phone Number _____

QRC (Qualified Rehabilitation Consultant) Name _____

QRC Phone Number _____

Auto or Work Comp Without Health Insurance

Often, an insurance company handling an auto or workers comp claim will make no guarantees of payment before they receive a bill. They reserve the right to deny a claim once the bill is received.

*If a claim is denied, In Motion Therapy has two options to collect payment. We can bill the client's health insurance, or we can bill the client directly. For this reason, it is standard procedure at our clinic to gather information about your health insurance, even if the fee for services are going to be submitted to an auto or work comp claim. This allows us to utilize the health insurance as a backup measure.

*If the client does not have health insurance, or chooses not to provide In Motion Therapy with his/her health insurance, our only option is to bill the client directly if the claim is denied. For this reason, we ask you, the client to read and sign this agreement:

"I, the undersigned, am not providing In Motion Therapy with health insurance information. I understand that, because of this, I will be billed for my treatment in the event my work/auto claim is denied. I accept responsibility for any/all charges that my insurance company chooses not to pay."

Signature _____ Date _____

Client's Printed Name _____