



Care at its Best!
www.performanceptri.com

The information on this page is to assist in the correct billing for the services provided to you at Performance when the injury is the result of a work related injury, Motor Vehicle Accident or any other slip/fall/accident when an attorney is involved.

Name: _____ Date of Birth: _____

Private Health Information: *(We are required to collect this information for all patients).*

Please provide a copy of your insurance card OR complete the following;

Insurance Company: _____ Policy Number: _____

Policy Holder: _____

Attorney Information:

Name: _____ Phone: _____

Address: _____

(Please sign Lien to authorize payment to Performance Physical Therapy upon settlement)

Work Related Injuries:

Place of Employment & Address: _____

Workers Comp Adjuster: _____

Date of Injury: _____ State of Injury: _____

Motor Vehicle Accident:

Primary Auto Ins. Carrier: _____ DOI: _____ Claim#: _____

Adjustors Name: _____ Phone: _____

Have you filed a claim with your Auto Insurance (please circle)?: yes / no

3rd Party Auto Ins: _____ Claim#: _____

Adjustors Name: _____ Phone: _____

By signing below, I attest that all information I provide is true and correct. I have read, understood and accept the policies stated above.

Patient signature: _____ Date: _____

Patient Care Coordinator: _____ Date: _____

Thank you for Choosing Performance Physical Therapy!