FOCUS PHYSICAL THERAPY

Patient Name:_____Date:_____

**MOTOR VEHICLE**
**ACCIDENT and CLAIM INFORMATION***

Admin: ☐ Check Complete

Injury Date _____
Social Security Number _____
Auto Policy Name _____Claim Number _____
Street Address _____
City _____ State _____ Zip _____

Adjuster Name _____
Adjuster Phone _____
Adjuster Email _____

*Please give claim information and private insurance card to staff for scanning.

Please complete the next section if you have an attorney for your case:

**MVA LETTER OF PROTECTION**

As consideration for therapeutic services received, I hereby irrevocably assign to Focus Physical Therapy, Inc., (hereinafter referred to as "Focus") out of the proceeds that would otherwise be payable to me out of any settlement, judgment or other recovery from my claim for personal injuries which occurred on _____(Date of Accident), such sums sufficient to pay in full all amounts I owe to the Clinic for my care for those injuries.

I direct my attorney, _____ (Name) to pay the Clinic directly out of the proceeds of any settlement or recovery, after paying attorney fees and costs and any valid hospital lien, any and all amounts I owe to the Clinic for care provided for my injuries. I understand that this means that before any proceeds are paid to me my attorney will pay directly to the Clinic the amount necessary to pay any outstanding amount I owe the Clinic for my care. I further agree not to rescind this agreement and instruct my attorney not to honor any attempt by me to rescind this agreement.

I understand and agree that I am directly and fully responsible to pay the Clinic for all services provided to me. I am entering this agreement to provide the Clinic additional protection for payment of my outstanding bill and in consideration of Clinic's forbearance of immediate payment. I also understand that if I do not receive a settlement or recovery in my personal injury case, or if the amount is not enough to pay all fees, costs and outstanding bills, I am still personally responsible to pay the Clinic for all amounts I still owe.

If my balance reaches $5,000 I agree to make payment in full for each visit so that my outstanding balance does not exceed $5,000. If my case has not been settled at the time of my discharge from care, I agree to make additional monthly payments of a minimum of $35.00 or 8.5% of the balance, whichever is greater, to the Clinic until such time as my case has been settled or until the balance of my bill has been paid in full.

**Both Patient and Attorney (page 2) are required to Sign:**

_____
Date

_____
Signature of Patient

_____
Print Name

_____
Driver's License Number

_____
Date of Birth

FOCUS PHYSICAL THERAPY

Patient Name:_____ Date:_____

As the Attorney of record for the above patient, I agree to observe the terms of this agreement and to act in accordance with the agreement between the Clinic and my client by paying directly from the proceeds of any settlement, judgment or recovery that patient is entitled to receive after attorney fees and costs and any valid hospital liens are paid.

_____ _____

Date Signature of Attorney

_____

Street Address

_____

City, State, ZIP

_____

Phone Number

**ATTORNEY**: Please date, sign and return original copy to:
Focus Physical Therapy, Inc.
1239 NE Medical Center Drive Suite 200
Bend, OR 97701-7359
541-385-3344 Phone
541-312-5256 FAX

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