OrthoSportsMED™
Physical Therapy

Dear Patient,

Massachusetts Personal Injury Protection (PIP) Laws regarding auto accidents states that the initial $2,000 in medical bills and lost ways is paid by **YOUR AUTO INSURANCE CARRIER.** After the initial $2,000 in PIP benefits is exhausted, all medical bills are turned over to your health insurance. You are responsible to follow the guidelines of your health insurance such as getting authorizations.

If you do not have health insurance, you should sign a **GROUP HEALTH AFFIDAVIT** stating this so that medical bills can be submitted to your auto insurance carrier immediately to access the remaining $6,000 in PIP benefits.

Once your health insurance carrier pays all they are required to, the remaining balance is re-submitted to your auto carrier. **PLEASE BE AWARE THAT $8,000 TOTAL IS AVAILABLE IN MEDICAL AND LOST WAGES COVERAGE UNLESS YOU PURCHASE MEDPAY AS PART OF YOUR AUTO INSURANCE COVERAGE.**

As the no-fault party in an auto accident, you have the option to retain an attorney and sue for lost wages, outstanding medical bills and other damages not covered by PIP benefits. The statute of limitations to file suit or submit for PIP benefits is two (2) years from the date of the accident.

As a patient treating here as a result of an automobile accident or a general liability injury; we request that you sign the following forms in addition to the required routine authorization forms in order to protect you and OrthoSportsMED Physical Therapy*

1. **ATTORNEY LIEN:** This directs your attorney to pay OrthoSportsMED Physical Therapy directly out of the portion of your settlement. If you do not have an attorney at the start of your therapy we request that you notify us immediately should you retain an attorney at a later date, in order that the appropriate paperwork can be processed.
2. **GROUP HEALTH AFFIDAVIT:** This is being signed if you do not have health insurance in order to access the additional PIP benefits.

Please be aware that you ultimately responsible for all charges incurred during your course of treatment while a patient at OrthoSportsMED Physical Therapy

Patient or Guardian Signature

Date

* OrthoSportsMED is the trade name for Orthosports & Aquatic Physical Therapy, PC*

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Lien Form

I, _____ do hereby authorize and direct **my attorney**, _____, to pay directly to *OrthoSportsMED Physical Therapy* any sum that may be remaining on my account with them at the time of settlement of my accident case and to withhold such sum from any settlement, judgment, or verdict as may be necessary to adequately protect *Orthosports & Aquatic Therapy, PC.*

DATE: _____ Patient's Name: _____

Witness: _____ Patient's Signature: _____

The Undersigned, _____, being Attorney of record for the above patient, does hereby agree to accept the terms of the above and agree to withhold such sum from any settlement, judgment, or verdict as may be necessary to adequately protect said *OrthoSportsMED Physical Therapy,* above named, for their services to my client.

DATE: _____ Attorney's Name: _____

Witness: _____ Attorney's Signature: _____

Note: Attorney: (1) Please date, sign and return original to:

OrthoSportsMED Physical Therapy
PO Box 920370
Needham, MA 02492
Phone: (781) 444-1290
Fax: (866) 305-1388

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Group Health Affidavit

I am not now eligible under any group health, sickness or disability insurance. If I become eligible during the two (2) years following the date of accident, I will notify OrhtoSportsMED Physical Therapy and the primary insurance company.

"Any person knowingly and with intent to defraud any insurance company or other person, files a statement of claim containing any materially false information or conceals, for the purpose of misleading, information of concerning any fact material thereto, commits a crime and my be subject to criminal prosecution and civil penalties."

Date: _____ Patient's Name: _____

Witness: _____ Patient's Name: _____

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