BreakThrough Physical Therapy, Inc.
263 N. Mathilda Avenue
Sunnyvale, CA 94086
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Motor Vehicle Accident Information

Name_____ Date_____

Date of injury _____

Has responsibility been determined? ◉ Y ○ N (state whom) _____

Are you currently working with a lawyer or involved in any litigation? ◉ Y ○ N

How did the accident happen?

_____

_____

_____

Your Auto Insurance

Insurance _____ Policy # _____ Claim#_____

Claim Address _____

Adjuster's Name _____ Phone w/ ext _____

Adjuster's Fax _____

Does your plan have Med Pay? ○ Y ◉ N? if so, how much? _____

3rd Party Auto Insurance

Insurance_____ Policy # _____ Claim #_____

Subscriber Name_____ D.O.B _____

Claim Address _____

Adjuster's Name _____ Phone w/ ext _____

Adjuster's Fax _____

Your Health Insurance

Insurance Name_____ Subscriber _____ DOB_____

Member ID _____ Group # _____

☐ By checking this box, I certify that I have provided the most accurate information to the best of my knowledge. I also understand that by not providing the information requested, it could result in a delay of care. **Motor vehicle accident cases are accepted at BreakThrough on a case by case basis and will not be accepted if I am involved in, or intend to become involved in, any litigation involving this accident.**