

Accidents or Injuries cont.....

Case Adjuster Fax#: _____

Name on Car Insurance

Policy: _____

Mail Claims to (address): _____

City: _____ State: _____

Zip: _____

Is there an attorney involved? Yes No

Attorney Name: _____ Phone #: _____

Is this a liability Case? Yes No

Date of Injury: _____

Place of Injury: _____

Contact Person: _____ Phone: _____

Claim #: _____ Fax#: _____

Mail Claims to
(address): _____

City: _____ State: _____

Zip: _____

Is there an attorney involved? Yes No

Attorney Name: _____ Phone #: _____

I attest that the information that I have provided on this form is complete and accurate to the best of my knowledge.

I hereby authorize Community Orthopedics Surgery, P.C. to furnish any medical information necessary to process my insurance claim (s) for my treatment acquired in the course of the examination or hospitalization.

I authorize payment of medical and/or surgical benefits to Community Orthopedic Surgery, P.C.

*By signing this form you acknowledge that you understand the provider's charge may exceed the insurance allowed amount and payment. You will be responsible for any balances, such as co-insurance, co-payments and deductibles. We accept: **VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS, CASH, OR CHECK.***

Name (please print)

Date

Patient's Signature (parent or guardian if patient is under 18 years of age)