



NEW MILFORD ORTHOPEDIC ASSOCIATES, P.C.

MOTOR VEHICLE INSURANCE

Patient Name _____ Gender: Male _____ Female _____

First Middle Last

Date of Birth ____/____/____ Social Security # ____ - ____ - ____ Driver's Lic.# _____

Home Address _____

City _____ State _____ Zip _____

Billing Address (if different) _____

Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____

Email Address _____

Marital Status S ____ M ____ D ____ W ____ Occupation _____

Primary Care Physician (PCP) _____ PCP Phone (____) _____ - _____

Guardian's Name (if a minor) _____ Relationship to Patient _____

Patient's Employer _____ Work Phone (____) _____ - _____

Employer's Address _____

Spouse's Name _____

Spouse's Employer _____ Spouse's Work Phone (____) _____ - _____

Spouse's Employer's Address _____

If full-time student indicate school currently attending _____

Emergency Contact _____ Phone (____) _____ - _____

MOTOR VEHICLE INSURANCE INFORMATION - FILL OUT IF YOU WERE INJURED IN A CAR ACCIDENT

Insurance Company: _____
(FOR VEHICLE YOU WERE IN AT TIME OF ACCIDENT)

Insurance Company Address: _____ Phone (____) _____ - _____

File #: _____

Date of Accident: ____/____/____ Policy #: _____ Claim #: _____

CITY STATE ZIP

Name of Insured (If other than Claimant): _____

Address of Insured: _____ Date last Worked: ____/____/____

Location of Accident: _____

CITY STATE ZIP

Body Part(s) Injured: _____

History of Accident: _____

In consideration of services rendered to me, I hereby authorize payment directly to New Milford Orthopedic Associates, P.C., of any and all first party no-fault automobile insurance benefits to which I may otherwise be entitled for services rendered by the provider, but not to exceed the provider's regular charges for such services.

In the event the provider's charges are outstanding and I fail to file an application for benefits under the Connecticut State Insurance Law, I hereby authorize the provider to file such claim in my behalf so that the provider may realize payment of its charges. I understand that, if the provider does not receive payment from the insurer, I am personally responsible for the payment of the provider's charges.

Signed: _____

I hereby authorized New Milford Orthopedic Associates, P.C. to release medical information on my injury to the motor vehicle insurance carrier _____

Signed: _____

PRIMARY INSURANCE CARRIER _____

Policy # _____ Group # _____ Phone (_____) _____ - _____

Address _____

Guarantor's Name _____ Relationship to Patient _____

Guarantor's SS# _____ - _____ - _____ Guarantor's Date of Birth ____/____/____

Employer _____ Employer's Phone (_____) _____ - _____

SECONDARY INSURANCE CARRIER _____

Policy # _____ Group # _____ Phone (_____) _____ - _____

Address _____

Guarantor's Name _____ Relationship to Patient _____

Guarantor's SS# _____ - _____ - _____ Guarantor's Date of Birth ____/____/____

Employer _____ Employer's Phone (_____) _____ - _____

ASSIGNMENT OF BENEFITS: I authorize payemnt of benefits directly to New Milford Orthopedic Associates, P.C. for services rendered. For purposes of payment or audit, I authorize the release of any informaiton acquired in the course of my examination or treatment; I understand that I am financially respnsible to the provider for charges not covered by my benefit plan.

SIGNED: _____ **DATE:** _____

I understand that I am personally responsible to the provider for payment for services rendered.

SIGNED: _____ **DATE:** _____

BILLING INFORMATION ACKNOWLEDGMENT

I, _____, understand and agree that it is my responsibility to be familiar with my medical insurance policy. I agree to provide correct referrals and authorizations. I will pay in full at the time of service if I do not have this information, and I accept responsibility for payment of the entire bill.

Furthermore, I accept and understand that any balances not covered by my insurance(s) are to be paid upon receipt of my bill. If my insurance company has not provided payment, I am responsible for the balance and for contacting the insurance company.

I agree that if my balance due to New Milford Orthopedic Associates, P.C. remains unpaid I will be responsible for interest on the unpaid balance at the rate of 18% per annum, plus cost of collection and reasonable legal fees.

Name

Signature

Date