Rapides Orthopedic Clinic

Patient Name: _____

Accident Information Form

Was your injury caused by a work-related or auto accident: ( ) Yes ( ) No

Please read this statement and answer the following questions:

The following information MUST be obtained in order for your claim to be paid by your insurance company. As a courtesy service, we file these for you. If we do not receive payment from your insurance company within 90 days of the date of service, you will be responsible for the entire amount of the visit. The following questions reflect information your insurance company will require. Thank you for completing them to the best of your ability.

Insurance Questions Regarding Accident

1. What was the date of your injury?	
2. Where did your injury occur?	2a. In what state did your injury occur?
3. How did your injury occur?	
4. Was this injury work-related?	( ) Yes ( ) No
5. What was your occupation at the time of your injury?	
6. Are you still employed by this employer?	( ) Yes ( ) No ( ) N/A
7. Was this injury the result of an automobile accident?	( ) Yes ( ) No
8. Was a third-party responsible? If Yes, please give the name and address of the third-party.	( ) Yes ( ) No

9. Have you seen any other doctor or had any previous surgeries for this injury? ( ) Yes ( ) No
If Yes, please explain:

10. If your visit is being handled through workers compensation, please provide the following:

Adjuster's Name: Phone:

Permission to Treat, Insurance Assignment & Financial Responsibility

I, certify that I (or my dependents have insurance coverage with _____
I assign directly to Dr. _____all insurance benefits, if any, otherwise payable to me for all services rendered and give him permission to treat my orthopaedic condition(s). I further authorize the doctor to release all information required to secure payment of benefits and the use of this signature on all insurance submissions. I understand that I am financially responsible for all charges whether or not paid by the insurance company. ROC will file my insurance, however, it is my responsibility to pay all charges, in full, on any balances not paid by my insurance company after 90 days. In the event that it is necessary for ROC to place this account in collections, I agree to pay for any and all collection costs.

_____	_____	_____
Patient (or Guarantor) Signature	*Relationship*	*Date*