

Far Oaks Orthopedists, Inc.
LIABILITY POLICY

HOW DID THE ACCIDENT OCCUR: _____

DATE OF ACCIDENT: _____ TIME: _____

WHERE: (CITY) _____ STATE: _____

SELECT ONE OF THE FOLLOWING BILLING OPTIONS:

_____ My injuries are the responsibility of a third party. I am providing all third party information including company name, address, phone and contact person so that Far Oaks Orthopedists, Inc. can send itemized statements directly to them. I understand a period of 90 days will be allowed for the third party to make payment in full. **If payment in full has not been received within 90 days, I will pay \$50 per month on my account until a settlement has been reached. At that time payment in full becomes due. My first payment is due 90 days after today.**

COMPANY NAME: _____

ADDRESS: _____

PHONE: () _____ CLAIM NUMBER: _____

_____ I have not provided information about the third party. I will bill the third party myself. **I understand that I am responsible for payment at time of service for all charges.**

_____ Bill my private insurance, _____ I do not want Far Oaks Orthopedists, Inc. to bill the liability carrier in this case. In the event my private insurance carrier denies payment of my claims, I understand I will be responsible to make payment on my account.

PLEASE COMPLETE IF YOU HAVE AN ATTORNEY IN THIS MATTER

I have retained an attorney in this matter and authorize Far Oaks Orthopedists, Inc. to release requested information including medical information to him/her. I understand that I am not released from my above billing agreement by providing this information.

ATTORNEY: _____

ADDRESS: _____

PHONE: () _____

A copy of your private insurance card is needed for your file. It will only be used if you auto/liability claim is denied. If your private insurance carrier REQUIRES you to get a REFERRAL from you primary care physician to see a specialist, you should inform your primary care physician and ask that your chart be noted so if your claim is denied you will be able to obtain a referral.

PATIENTS NAME: (please print) _____

PATIENT / GUARDIAN'S SIGNATURE: _____ DATE: _____

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