THE GEORGIA INSTITUTE FOR PLASTIC SURGERY

Accident Details

PATIENTS NAME: _____ **DATE OF BIRTH:** _____

Is your visit today the result of one of the following:

❒*Work Related* ❒*Auto Accident* ❒*Accidental* ❒*Fall* ❒*Animal* ❒*Bite* ❒*Other Injury:*

If YES, please complete the following:

What happened? _____

Where did the accident occur? _____

When did the accident occur? (Date) _____

Is there any other insurance coverage (such as a *Homeowner's Policy, School Insurance, Worker's Compensation, etc.*) that will pay this bill?

❒**YES** ❒**NO**

If YES, please provide the following information for that Insurance Company:

NAME, INSURED'S NAME: _____

INS CO ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

PHONE POLICY# CLAIM NUMBER ADJUSTERS NAME: _____

ATTORNEY'S NAME, ADDRESS, PHONE: _____

IF WORK RELATED: WAS INJURY REPORTED TO EMPLOYER? ❒**YES** ❒**NO**

If Y**ES**, list the name of person you spoke with: _____ Phone #: _____

Employer Name: _____ Phone #: _____

Employer Address: _____

AUTO ACCIDENT / OTHER ACCIDENT

When your injuries are the result of an accident and an attorney will be handling your case in court or another party's insurance company is presumed responsible for your charges, the patient is still responsible for payment of the bill. The Georgia Institute For Plastic Surgery cannot be expected to wait for the conclusion of long-term court cases or settlement of a disputed insurance claim before being paid. ***You will be required to make a payment of $350 before being seen and with EACH visit that follows. You also are responsible for payment of the balance of your bill should charges exceed the $350 you pay at each visit.***

WORKER'S COMPENSATION

Patients who are injured on the job should report the injury directly to their employer. The employer will be responsible for directing the employee to a doctor who is listed on their Panel of Physicians. Before we will be able to see you as a patient we will require you to fax or bring in a letter verifying that your employer will be responsible for your charges. If a patient comes in for a visit without this information, we will have to reschedule the appointment. This information is necessary to avoid the patient from being responsible for the bill.

Signature of Patient or Guardian: _____ **Date:** _____