Patient #: _____

Appointment Date: _____

The Centers for Advanced Orthopaedics

Potomac Valley Orthopaedic Associates

AGREEMENT TO PAY MEDICAL COSTS IN THE EVENT THAT WORKMAN'S COMPENSATION/AUTO ACCIDENT CLAIM IS DENIED

Please Print all information

PATIENT'S NAME: _____ _____ _____
(Last Name, First Name, Middle Initial)

DATE OF ACCIDENT: _____

BODY PART: _____

AUTO/WORKMAN'S COMP INSURANCE NAME: _____
ADDRESS: _____
CITY/STATE: _____ ZIP: _____
PHONE #: _____ POLICY #: _____
CLAIM #: _____
(This is different than the policy #- this is the # given to your injury claim)
ADJUSTOR NAME: _____ PHONE #: _____

ATTORNEY NAME: _____
ADDRESS: _____
CITY/STATE: _____ ZIP: _____
PHONE #: _____

EMPLOYER INFORMATION (If this is a Workman's Compensation Claim)
EMPLOYER'S NAME: _____
ADDRESS: _____
CITY/STATE: _____ ZIP: _____
PHONE #: _____

INSURANCE AUTHORIZATION AND ASSIGNMENT (Please Read and Sign)
In consideration of services rendered, I hereby assign The Centers for Advanced Orthopaedics Potomac Valley Orthopaedic Associates division, so much of my Auto Accident/Workman's Compensation Insurance Benefits and rights as shall equal the full amount of the bill. If the Insurance Company/Compensation Board determines that the illness/condition is not related to the accident, I agree to remain personally liable for the usual fees for the services provided. In addition, I permit The Centers for Advanced Orthopaedics Potomac Valley Orthopaedic Associates division to release any and all Medical Records pertaining to my condition to the Insurance Company listed above.

PATIENT'S/GUARDIAN'S SIGNATURE (If patient is under 18 years old)

_____ Date: _____