



# ACCIDENT OR INJURY REGISTRATION FORM

(PLEASE COMPLETE ALL SECTIONS OF THIS FORM)

PATIENT INFORMATION	EMERGENCY CONTACT
TODAY'S DATE _____	NAME _____
PATIENT NAME _____	PHONE # _____
SS # (REQUIRED) _____	RELATIONSHIP TO PATIENT _____
DOB _____ SEX _____	
ADDRESS _____	AUTH. OR CLAIM #
CITY _____	
ST / ZIP _____	CASE WORKER / MANAGER NAME
HOME # _____	
WORK # _____	MEDICAL HISTORY (Previous Injuries)
CELL # _____	
DATE OF INJURY /ACCIDENT	NAMES OF CO-WORKERS or WITNESSES PRESENT
DESCRIPTION / TYPE OF INJURY	ANY TREATMENT SO FAR ?(ER VISIT, OTHER DOCTOR ETC.)

## EMPLOYER INFORMATION

EMPLOYER \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE \_\_\_\_\_

## W/C CARRIER OR AUTO INSURANCE INFORMATION

NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY, ST, ZIP \_\_\_\_\_

PHONE \_\_\_\_\_

# CONSENT FOR TREATMENT AND MEDICAL RECORDS RELEASE

## Consent and Authorization for Routine and Treatment:

I hereby consent to and authorize Vecina Medical, and my physicians or healthcare providers (both herein "Vecina") to provide medical care necessary for treatment of my medical condition.

Patient or Responsible Party \_\_\_\_\_ (Please initial)

## Assignment of Benefits:

I hereby assign Vecina and my providers payment from all third party payers with whom I have coverage or from whom benefits are or may become payable to me, for the charges of my healthcare services I receive for, related to, or connected with this visit and any future visit for which I have medical insurance coverage.

Patient or Responsible Party \_\_\_\_\_ (Please initial)

## Consent and Authorization for Release of Information: Cooperation:

I hereby authorize Vecina and my providers to release copies of my billing and medical records, and applicable healthcare information, to ensure payment for healthcare services I receive for, related to, or connected with this visit(s), to secure additional treatment if needed and to otherwise facilitate healthcare operations related thereto, to the following persons or entities: any Vecina provider, my referring or treating providers, the Guarantor on my accounts, and third party payers\* or their agents. I also authorize the release of my healthcare information to regulatory entities and accrediting organizations as necessary to secure payment for services provided to me.

Patient or Responsible Party \_\_\_\_\_ (Please initial)

## Guarantor Agreement:

I hereby agree to the following: (i) I am responsible for the charges of all healthcare services the "Patient" receives for, related to, or connected with this visit(s), and same are due and payable at the time of discharge or discontinuation of treatment. The charges I agree to pay are readily available from any Vecina staff member and am fully aware at the time the healthcare services are provided. (ii) If Vecina bills third party payers\*, they do as a courtesy, and Vecina may demand payment in full of any balance due, at any time. (iii) I understand that Vecina may bill me separately. (iv) If I am more than thirty (30) days overdue in the payment of any bill, a finance charge of 1.5% per month will accrue on the unpaid balance. (v) If I am more than one hundred twenty (120) days overdue on the payment of a final bill, I may be declared in default, and the overdue account may be referred to a collection agency, in which case I agree to pay attorney's fee, court costs and/or collection agency fees associated with the collection process.

\* Third party payers include, but are not limited to, coverage available from, Medicare, Tri-Care, or governmental programs; health, accident, automobile, or other insurance; worker's compensation; HMO (commercial, Medicare); self-insured employers; and any sponsors who may contribute payment for services.

## ***Our staff will do everything possible to verify your insurance benefits and eligibility. If treatment is AFTER HOURS or on WEEKENDS AND WE ARE UNABLE TO VERIFY YOUR MEDICAL INSURANCE COVERAGE***

*Please be advised that due to the nature of our practice, payment for physician services is expected at the time of service.*

*We accept Cash, Checks (must be imprinted with name and address and will be electronically scanned), Debit Cards, MasterCard, Visa American Express and Discover. Vecina Medical accepts most insurance plans and will be happy to file your insurance provided that eligibility, deductible and co-payment amounts can be verified prior to seeing the physician.*

*Otherwise, PAYMENT IN FULL WILL BE EXPECTED AT THE TIME SERVICE IS RENDERED*

*For your convenience, Vecina Medical can either submit the claim on your behalf to your insurance company or we will provide the appropriate form so that payment made to Vecina Medical can be reimbursed to you by your insurance company or applied toward your annual deductible, which ever is applicable.*

**\*\*\*PAYMENT POLICY MUST BE ACKNOWLEDGED AND ACCEPTED PRIOR TO SEEING THE PHYSICIAN\*\*\***

Payment Policy Acknowledged and Accepted by Patient or Responsible Party \_\_\_\_\_ (Initial)

By signature below, I acknowledge that I have read, understand, and agree to the foregoing as applicable to me, which shall also apply to Patient's child(ren) or legal dependent.

Patient/Guardian:

Date: