SOUTHLAND
– ORTHOPAEDICS –

20060 Governors Drive, Suite 300, Olympia Fields, IL 60461 | 10, Orland Square Drive, Orland Park, Il 60602
www.southlandorthopaedics.com | 708-283-2600

AUTO ACCIDENT PAYMENT POLICY

On the first visit following your accident, you will provide the name of the *automobile insurance company, address, phone number, claims adjuster and claim numbers* for all parties involved. In addition, a copy of the police report is needed. Personal/group information will also be obtained at this time.

The patient's automobile insurance will be billed as the *primary insurance*. Once medical med pay has been exhausted your personal/group insurance will billed and any balance remaining will be your responsibility. Our Office will send information to the other parties' insurance company, however that insurance never pays any bills until the claim is settled (which can take months, sometimes years).

If you obtain an attorney, our office will need that information.

Physician liens will be sent to all parties involved, e.g. your auto insurance, the other parties' auto insurance, as well as your attorney. This is to protect any remaining balance.

Payment for all services is ultimately the responsibility of the patient and the patient must provide all information and referrals (if applicable) to ensure that payment is made.

☐ I have read and understand the billing policy explained above, and herby authorize Southland Orthopaedics, Ltd. To provide necessary information to the name's insurance company and/or attorney in order to obtain payment. I also instruct said insurance company/attorney to honor physician's lien field by Southland Orthopaedics, Ltd.

____________________________ ____________________________

Signature of the Patient Date

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AUTO ACCIDENT INFORMATION SHEET

Appointment Date: ______________________________ **Time:** ______________________

Patient Name: __________________________________ **Phone:** ______________________

Social Security Number: __________________________ **Date of Accident:** ____________

Summary Accident: ____

____

Patient's Auto Insurance Info: ____

Insured Name on Policy: ____

Claim Address: ____

Adjuster: _________________________________ **Adjuster Phone No:** ________________

Claim No: _________________________________**Adjuster Fax No:** __________________

OTHER PARTIES INSURANCE INFORMATION

Insurance Company: ______________________________ **Claim No:** _________________

Claim Address: ____

Adjuster: ____________________**Phone No:**__________________ **Fax No**:______________

ATTORNEY NAME AND DETAILS

Attorney Name: _______________________________ Phone No: ______________________

Attorney Address: ____