PROLIANCE ORTHOPAEDICS & SPORTS MEDICINE
BELLEVUE • ISSAQUAH • REDMOND

Motor Vehicle Accident Information Sheet

Name: _____ **Date:** _____

This form is meant for you to provide us with accurate information about your accident should the insurance company or your attorney request it, or in case of the necessity of legal testimony. It may be referred to in other documents in your medical record in the future. If you have been in multiple accidents in the past the questions on this form should pertain to the accident you believe is most recent or most important to your symptoms. If you have been in other accidents in the past please provide us with a list of those accidents and the treatment you received for those on the back of this form. Thank You.

Date of Accident _____
City _____
Street _____
Make and Model of your Vehicle. _____
Make and model of other vehicle(s) involved. _____
How fast was your vehicle moving at the instant of the crash? _____
How fast was the other vehicle traveling at the instant of the crash? _____
Were you the ☐ Driver ☐ Passenger ?
Were you wearing a seat belt at the time ? ☐ Yes ☐ No
Does your car have a head rest ? ☐ Yes ☐ No

Did the accident involve:
☐ Head on collision ☐ Rear end Collision ☐ Hit from the Side - Which side? ☐ Rt. ☐ Lt.

☐ Didn't collide with another vehicle ☐ Hit stationary object? What? _____

How much damage was done to your vehicle in dollars? $_____ The other Vehicle $_____
Did your seat break? ☐ Yes ☐ No
Did you hit your head? ☐ Yes ☐ No
Did you lose consciousness? ☐ Yes ☐ No
Did you think you were hurt immediately? ☐ Yes ☐ No
If not, when did you first notice any symptoms? _____
And what were those symptoms? _____
When did you first notice your current symptoms? _____
Was anyone else in your vehicle at the time? ☐ Yes ☐ No
What injuries did they sustain? _____
Were you taken to the hospital? ☐ Yes ☐ No Which Hospital? _____
Did you have X-rays done? ☐ Yes ☐ No Of What? _____
Any other tests? _____
What were you told was wrong at that time? _____
Did you see any other physicians since then about this? If so please list IN ORDER below?

Doctor	Tests Done	Treatments Given

Is there a settlement pending? ☐ Yes ☐ No ☐ Already settled
Do you have an attorney assisting you with the settlement? ☐ Yes ☐ No
If so please give name, address and Phone here. _____

Proliance Orthopaedics and Sports Medicine Financial Policy

Proliance Orthopaedics and Sports Medicine, a division of Proliance Surgeons is committed to providing you with the highest quality medical care. Because patients are ultimately responsible for the charges associated with their care, even when insurance is in place, you may find the following information helpful. We realize you have choices for your medical care and appreciate your choosing Proliance Orthopaedics and Sports Medicine.

Patient Responsibilities

You can help ensure an efficient experience by assisting with the following:

- Providing us with your picture identification, insurance card and Social Security number to enable us to submit your claims timely and accurately
- Ensuring there is an authorization for our providers to treat you if it is required by your insurance, including obtaining a referral
- Providing us with copies of any pertinent medical records, including tests (MRI/CT/Arthrogram) and x-rays
- Knowing your insurance benefits and limitations
- Paying your co-payment at the time of service
- Paying any additional amount owed when due
- Completing required incident/accident forms within 30 days of date of service
- Maintaining a current account with Proliance Surgeons at all times
- Providing us with at least 24 hours advance notice should you need to cancel or reschedule an appointment

Please note that co-payments, co-insurance and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.

Insured Patients

We will bill your primary and secondary insurance carrier in a timely manner. If you are disputing payment with your insurance carrier or have a balance over $100.00 with us, you must notify our business office @ 425-507-0733 and make payment arrangements.

Co-Pays/Deductibles/Co-Insurance – Please be prepared to pay for your portion of the charges on the date of service.

Surgery – If surgery is indicated, a pre-payment of both physician and facility fees is required for all elective, non-emergent procedures prior to the surgery being performed. Your out-of-pocket cost is estimated based on your benefits and our fees. Anesthesia and other providers are separate fees.

Non-Participating Insurance – If we do not participate in the insurance you have you will be required to pay a deposit of $250.00, we will file a claim as a courtesy. All unpaid claims will become your responsibility 45 days following filing and be immediately due and payable.

Uninsured Patients

Office Visits – A $250.00 for new patient visits and $150.00 for follow up visits, deposit is required prior to the appointment. If visits and services are paid in full at the time of service, we offer a 20% discount (see exclusions below). Office visits may include x-rays, casting and materials at an additional charge. Charges are not finalized until chart notes are complete.

Surgery – For uninsured patients having surgery, we offer a 20% discount when charges are paid before or on the day of service (see exclusions below).

Exclusions – The discounts referenced above do not apply in cases of motor vehicle accidents, third party insurance claims or in other cases when the patient may be reimbursed in full.

Private pay patients who receive retroactive Medicaid coverage need to immediately notify our business office.

Motor Vehicle Accidents (MVA) Insured and Third Party Patients

A deposit as outlined above will be required. We do not extend discounts for MVA-insured accidents, third party insurance claims or in other cases when patients may be reimbursed in full. We will bill your MVA insurance carrier one time. The bill becomes your responsibility if not paid by the carrier in 30 days. We regret that we are not in a position to confer with attorneys or defer payment obligations while a case settles. If your personal injury protection benefit on your MVA policy is exhausted, we will bill your private insurance at your request provided we are furnished the necessary information at the date of service.

Workers' Compensation

If your visit is work-related, we will need the case number and carrier name prior to your visit in order to bill the workers' compensation insurance carrier. If your workers' compensation claim is not yet accepted and you have no other insurance, we require a $250.00 deposit that will be refunded after the claim has been opened.

Other Charges

No Show – Please provide us with at least 24 hours advance notice if you need to cancel or reschedule an appointment. We may charge a fee for missed appointments.

Please provide us with at least 48 hours advance notice if you need to cancel or reschedule an appointment and an interpreter has been scheduled. Otherwise, you may be charged for the interpreter.

Forms – There may be a charge associated with our completion of some forms. We require payment of the charge before returning the completed form to you. A signed Release of Information may also be necessary. Please allow five business days for us to complete forms.

Payment

Payment Options – We accept cash, checks, major credit/debit cards and money orders for payment (no post-dated or third party checks). We charge a $40.00 NSF fee for any returned checks.

Delinquent Accounts – We charge a $10.25 monthly account management fee on balances over 45 days old. We may assign an account to collections if balances are unpaid after 60 days. Patients assigned to collections may be denied additional service.

Alternative Payment Arrangements – If you are unable to pay your balance when due, please contact our business office to make alternative arrangements. Any patient with a past due amount may be denied additional service until the amount is paid or the patient is complying with an alternative payment arrangement.

Bankruptcy/Prior Bad Debt – Patients who have previously filed for bankruptcy or never satisfied their payment obligations for prior episodes of care with Proliance Orthopaedic and Sports Medicine or other Proliance Surgeons care centers may be required to pay for their portion of new charges *and/or deposit* at the time of service.

These policies are subject to change without notice. Please check our website at www.pro-osm.com for any changes.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Signature of Co-Responsible Party Date

_____ _____

Patient Name (Please Print) Date