

Third Party Liability/Worker s Compensation Information Form

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____ SS#: _____

Address: _____ City/State/Zip: _____ Phone: (____) _____

Date of Accident: _____ Date First Treated: _____ Where (ER, Clinic, etc.): _____

How did accident happen? _____

EMPLOYER S WORKER S COMPENSATION INSURANCE CARRIER

Insurance Company Name: _____

Address: _____ City/State/Zip: _____

Phone: (____) _____ Fax: (____) _____ Email: _____

Name of Insured: _____ Policy #: _____ Claim #: _____

Date employer notified of illness/injury: _____ Adjuster handling your claim: _____

THIRD PARTY LIABILITY INSURANCE INFORMATION

(If injuries are related to a personal injury or automobile accident)

Insurance Company Name: _____

Address: _____ City/State/Zip: _____

Phone: (____) _____ Fax: (____) _____ Email: _____

Name of Insured: _____ Policy #: _____ Claim #: _____

Adjuster or Agent handling your claim: _____

IF YOU HAVE RETAINED AN ATTORNEY S SERVICES

Attorney s Name: _____

Address: _____ City/State/Zip: _____

Phone: (____) _____ Fax: (____) _____ Email: _____

JEFFREY F. KLEIN, M.D., F.A.A.F.P.

A MEDICAL CORPORATION

**AGREEMENT FOR THIRD-PARTY LIEN AND
MEDICAL RECORDS RELEASE AUTHORIZATION**

PATIENT NAME: _____ SUBSCRIBER NAME: _____

DATE OF INJURY/ACCIDENT: _____ ATTORNEY S NAME: _____

Your Evidence of coverage and Service Guide contains a reduction clause for injuries or illnesses caused by third parties. This clause is reproduced on the reverse side of this form for your review.

The clause means that if you or any member of your family who is enrolled as a health plan member suffers an injury caused in some manner by a third party, and subsequently collects money on account of that injury from the third party, his employer or insurers, you or the family member are required to reimburse Jeffrey F. Klein, M.D., at non-member rates, the charges for the hospital and medical services, and other benefits provided for the treatment of the injury including any payments made by the health plan to non-plan providers in the Out-of-Plan Emergency Care benefit. You are required to reimburse us whenever you have received such a payment on account of the total amount of the recovery. For additional information, please call your insurance or HMO member services department.

To: Jeffrey F. Klein, M.D.

I have read the Third Party Responsibility Clause, and have read and understood the terms printed on the reverse side of this form. I hereby authorize and direct my attorney and/or insurance company to pay Jeffrey F. Klein, M.D. the full amount of charges for hospital and medical services and all other benefits rendered to me in connection with my third-party injuries or illnesses.

If I have no attorney or my attorney and/or insurance does not make appropriate payment, I will be directly responsible for all charges and will pay with funds received from my settlement or judgement. If these funds are paid directly to me, (patient or legal guardian or parent of minor) I understand that I am responsible to reimburse Jeffrey F. Klein, M.D. in full for all services rendered or provided.

I further understand that my failure to pay the amounts due at the time of settlement or judgement is a violation of my insurance or HMO agreement and may result in legal action and /or termination from the health plan.

I hereby authorize Jeffrey F. Klein, M.D. to release all medical records and data concerning my injuries or illness to my attorney and/or insurance company. I hereby acknowledge that financial billing statements are not provided unless this document and the lien are signed, as I have no directly incurred costs for care.

A photocopy of this authorization is considered as valid as the original when executed below.

Patient s (or Parent/Guardian) Signature

Date

Attorney s Signature (if applicable)

Date

HMO EVIDENCE OF COVERAGE AND SERVICE GUIDE

THIRD PARTY RESPONSIBILITY

Third party responsibility (including Worker s Compensation) refers to the liability which a third party may owe or incur to a member. This includes (a) the responsibility of a third party or his or her insurer for a negligent or intentional act or omission causing injury or illness to the HMO member, or (b) the responsibility of any employer or the employer' insurer to the member under a program of worker s compensation.

Where such third party responsibility exists, the primary care physician (PCP) or primary medical group (PMG) will bill the member for the usual and customary charges for services provided and cost incurred. Should the member recover any sum from the responsible third party, the PCP or PMG should be reimbursed out of such recovery from a third party for the amounts billed by the PCP or PMG. Thee member grants to the PCP or PMG a claim and a charge and a lien against any amounts so recovered through settlement, judgement or verdict.

If the member does not recover any sum from said third party, he or she shall pay ONLY the applicable co-payments and the cost of any items not specified as covered. The member may be required by the PCP or PMG to execute documents and to provide information necessary to establish the claim or to ascertain the right of recovery.