COMPLETE EMERGENCY CARE

MOTOR VEHICLE ACCIDENT

PATIENT INFORMATION

Last Name _____ First Name _____ Middle _____

Date of Birth _____ /_____ /_____ Age _____ Sex ☐M ☐ F Email_____

Address _____ APT #_____ City _____ State _____ Zip _____

Cell Phone (_____) _____ - _____ Home Phone (_____) _____ - _____

Employer _____ Work Phone (_____) _____ - _____

Emergency Contact Name_____ Relationship _____ Phone (_____) _____ - _____

ACCIDENT DETAILS

Date of Accident: ___/___/___ Time of Accident: ___:___ a.m. –or – p.m.

Have you reported the accident to your auto insurance company? Yes ☐ No ☐

If yes, when? ___/___/___

Have your filed a PIP or NO FAULT application with your auto insurance carrier? Yes ☐ No ☐

Claims will be paid by: ☐ Your insurance ☐ the other driver's insurance

AUTO INSURANCE

Insurance Carrier's Name_____ Is this: ☐ yours ☐ other driver's

If other driver's information, what is their name? _____

Address for Claims: _____

Effective Date of Policy: _____/____/____

Policy Number #:_____ Claim Number #: _____

Adjuster's Name _____ Phone Number _____

YOUR MEDICAL INSURANCE

Carrier _____ Policy Holder Name _____

Member ID_____Group # _____ Date of Birth_____/_____/_____ Sex ☐M ☐ F

Phone _____ Relationship to Patient: ☐ Self ☐ Parent ☐ Guardian ☐ Spouse

PRIVACY PRACTICES & PATIENT RIGHTS

By signing this form, I acknowledge that a copy of the Notice of Privacy Practices of Complete Emergency Care is available to me upon request and can be downloaded at www.completeemergencycare.com. Further, I acknowledge that I have been provided with a copy for review and/or take home of "Patient Rights and Responsibilities".

ANCILLARY SERVICES

_____ **Initial**: Your ER Physician may recommend certain laboratory and/or radiology tests to help aid in the treatment and diagnosis of your condition. . Some of these tests are not routinely performed in our facility. Your laboratory test may be sent to one of the following independent laboratories; _____ or _____. Should an x-ray or CT be required, the test will be performed here and an independent radiologist will read and interpret the x-ray or CT and provide a report on their findings. _____ Radiology is an independent company and you will be billed separately for these interpretation charges only. **You may receive a separate bill for services provided by an outside lab and/or radiology reading. This is not a bill from Complete Care. Complete Emergency Care is not responsible for these charge.**

LEIN NOTIFICATIONS

_____ Initials: A lien in the amount of the submitted charges will be sent to the auto insurance with a copy of our claim. This lien is not against you or any of your property. The lien will help shift liability to the auto insurance and we will first seek payment from the policy. The purpose of the lien is to assure the insurance company or any settlement pays us for the charges associated with your accident. We will limit your involvement in the billing process and can focus instead on your recovery.

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Patient Name: _____

RELEASE OF INFORMATION

Release of Medical Records: By signing this form I authorize Complete Emergency Care to release verbally, electronically, and/or in writing my confidential medical information for purposes of treatment, payment of charges, quality assurance and utilization review, transfer and follow-up procedures to my insurance carrier, employer (if treatment is related to employment), other healthcare providers. **I also approve the release of my medical records to the following person(s).**

Name: _____ Name: _____

Relation: _____ Relation: _____

Phone: _____ Phone: _____

☐ I hereby authorize the release of my **COMPLETE** health record (including records relating to mental health care, communicable disease, HIV or AIDS, and treatment of alcohol/drug abuse).

OR

☐ I hereby authorize the release of my **COMPLETE** health record **WITH EXCEPTION** of the following information:

□ Mental health records
□ Communicable diseases (including HIV and AIDS)
□ Alcohol/drug abuse treatment
□ Financial Account information
□ Other (please specify):_____

OR

☐ I hereby authorize the release of following information:
□ Records for dates of service from_____to _____
□ Narrative reports □ Lab results □Hospital records □ Pathology results □ Radiology results

AUTHORIZATIONS AND CONSENT TO TREAT

Authorization of Treatment: By signing this consent form, I voluntarily consent to the administration, treatment and cost of surgical procedures, radiology procedures, medication and other ancillary medical services for myself or my dependent. I understand that a copy of this consent form may be used with the same effectiveness as the original.

____ Initial: **I understand Complete Emergency Care is an emergency facility and is billed as an emergency room visit including a facility fee to my insurance or third party payor.**

Guarantee of Payment: If insurance is filed on my behalf for charges associated with care provided by Complete Emergency Care and the company's assigned physician group, **I assign to the provider all payments from insurance companies or third party payors**. CEC may use and disclose my healthcare information to an insurance company or third party payor for the purposes of payment if a claim is filed on my behalf. I acknowledge that if CEC submits a claim to my insurance carrier, it is done so as a courtesy and that I am ultimately responsible for all charges incurred, unless both parties mutually agree otherwise. I agree that I will pay my estimated out of pocket based on the best available information of my current policy and understand this is only an estimate. While CEC makes every effort to verify my correct insurance information, I understand CEC cannot guarantee the accuracy of my bill until it has been fully processed by my insurance carrier. **If insurance will not be filed on my behalf, I agree to pay for all services rendered in full at the time of the visit.** By electing to be self-pay, I understand that any insurance that may be in effect at the time of service will not be billed by CEC and I will receive a global non-itemized receipt. An itemized receipt will not be available at the time of service or anytime in the future. I understand that if paying by check and it is returned, a processing fee of $30 will be assessed. I attest that the information provided to CEC and written herein is true and accurate.

Patient Signature: _____ Date: _____

**All references to Complete Emergency Care (CEC) include the company's physician group CEC ER Physicians PLLC.*