

PENNSYLVANIA ORTHOPAEDIC CENTER

MOTOR VEHICLE ACCIDENT REGISTRATION

PATIENT INFORMATION

Patient Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone #: (Home) _____ (Work) _____

INSURED INFORMATION

(complete only if different than patient)

Insured Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Telephone #: _____

AUTO INSURANCE INFORMATION

Insurance Carrier: _____

Address: (to send claims) _____

City: _____ State: _____ Zip Code: _____

Telephone #: _____ Adjuster's Name: _____

Claim #: _____ Date of Accident/Injury: _____

In the state of Pennsylvania, auto insurance is considered "no fault" insurance. Therefore, **your** auto insurance is responsible for payment, regardless who is at fault or if you were a passenger in someone else's vehicle.

I understand that if my auto insurance does not pay or becomes exhausted of benefits:

(1) I will be personally responsible for payment of all unpaid claims made by PAOC/Ruggiero Orthopaedic Assoc., Ltd. and; (2) I am responsible to obtain all applicable referrals required from my personal primary health insurance carrier for services provided by PAOC/Ruggiero Orthopaedic Assoc., Ltd. In the event that I do not provide my personal primary insurance and/or applicable referrals, I will be personally responsible for all unpaid claims.

Signature of Patient / Parent / Guardian

Date

Print Name of Patient / Parent / Guardian