REGENCY MEDICAL CENTER
WORKMAN'S COMP. / MVA INFORMATION

PLEASE COMPLETE THIS FORM IN ITS ENTIRETY:
ANY MISSING INFORMATION *MUST* BE PROVIDED TO REGENCY MEDICAL CENTER WITHIN 24 HOURS OF TREATMENT OR PATIENT BECOMES FULLY LIABLE FOR ALL CHARGES INCURRED.

Patient Name:__________________________ **Date:**___/___/____ **Date of Birth:**___/_____/____

For minors, name of Parent/Guardian:____

Date of Incident/Accident: ___/_____/_____

Patient phone number:____

Injury(ies):____

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FOR A WORKMAN'S COMP. CLAIM, COMPLETE THIS SECTION…

Contact name:____

Claim number:____

Bill to:____

Address:____

____

Phone number:____

FOR A MOTOR VEHICLE ACCIDENT (MVA), COMPLETE THIS SECTION…

Insurance name:____

Insurance phone number:____

Contact name:____

Policy holder:____

Policy number:____

Claim number:____

Claim address:____

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FINANCIAL RESPONSIBILITY STATEMENT

I UNDERSTAND THAT I AM LEGALLY RESPONSIBLE FOR ALL CHARGES INCURRED IN CONNECTION WITH THE MEDICAL CARE AND TREATMENT PROVIDED BY REGENCY MEDICAL CENTER (RMC). I HEREBY AUTHORIZE AND DIRECT PAYMENT OF MY MEDICAL EXPENSES TO RMC FOR ANY SERVICES FURNISHED TO ME RELATING TO THE ABOVE NAMED INCIDENT/ACCIDENT FROM THE THIRD PARTY PAYOR. I AUTHORIZE RMC TO RELEASE ANY INFORMATION INCLUDING ANY DIAGNOSIS, TREATMENT, AND EXAMINATIONS RENDERED TO ME/MY DEPENDANT FOR SUCH MEDICAL SERVICES TO THE THIRD PARTY PAYOR LISTED ABOVE. IN THE EVENT THAT ANY SERVICES ARE DETERMINED TO BE "NOT COVERED" OR OF ANY DEFAULT OF PAYMENT BY THE THIRD PARTY PAYOR, I UNDERSTAND AND AGREE THAT I WILL BE RESPONSIBLE FOR PAYMENT OF THE COMPLETE CHARGES FOR ALL UNPAID SERVICES.

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Patient OR Parent/Guardian signature ***Date***