REGIONAL ORTHOPEDIC Professional Association
WWW.ROPANJ.COM
PHONE 856-663-7080
FAX 856-663-4945

REGIONAL RENEW
WWW.REGIONALRENEW.COM
PHONE 856-675-3380
FAX 856-406-6646

ATTORNEY CO-PAY AND DEDUCTIBLE

PATIENT NAME: _____

DATE OF INJURY: _____

I hereby authorize Regional Orthopedic, PA to send a copy of my outstanding invoices for medical treatment directly to my attorney's office.

I understand I will not receive a copy of the statements unless I contact the billing office and request a copy.

When my case closes or settles, I understand that is my responsibility to notify Regional Orthopedic, PA as well as instruct my attorney that any outstanding invoices Regional Orthopedic or paid out of my settlement. Otherwise I may receive a bill for services rendered up to 6 years from the initial date of treatment.

_____

SIGNATURE OF PATIENT DATE

I DO NOT HAVE AN ATTORNEY. I WILL PAY ANY OUTSTANDING INVOICES INCLUDING COPAY AND DEDUCTIBLES **AS THEY OCCUR**. WHEN/IF I RETAIN AN ATTORNEY, I WILL INFORM REGIONAL ORTHOPEDIC.

_____

SIGNATURE OF PATIENT DATE