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MVA

Dear Patient:

Motor Vehicle bills are paid according to a published fee schedule. Although coverage may differ from person to person, most policies have at least a $250.00 deductible and the insurance company then will reimburse the provider 80% of the allowed amount up to $5,000. It may be necessary to file your claims to your medical insurance after your motor vehicle insurance has processed your claim.

Should your medical coverage be an HMO with which we participate, it is the patient's responsibility to contact the PCP and obtain a referral.

If we do not participate with your health insurance, we will file a claim on your behalf after your MVA carrier has processed your claim.

If the reason you are coming to our office is due to a ***motor vehicle accident***, please answer the following:

Date of Accident: ____ / ____ / ____

Describe the circumstances:
____
____
____
____

Were you hospitalized?: Yes / No

What hospital were you admitted to?: ____

What doctors were in attendance?: ____

Were any X-Rays taken?: Yes / No Type of X-Ray?: __________________________

What type of treatment did you receive?: ____

If you lost time due to your accident, please provide the dates: ____ / ____ / ____ -until- ____ / ____ / ____

If you have any questions, please contact Maria in the Business Office @ 201.493.0794

Signature: __________________________________ Date: ____ / ____ / ____

Patient Name: _______________________________ Date: ____ / ____ / ____

(continued on next page)

1200 East Ridgewood Avenue • East Wing, Suite 208 • Ridgewood, New Jersey 07450 • Tel: (201) 444-0868 • Fax: (201) 447-0581

ASSIGNMENT OF BENEFITS (MVA)

Patient's Name: ____

Patient's Address: ____

Date of Loss: ____ / ____ / ____

Insurance Company: __________________________ Name of Policyholder: ________________________

Policy Number: ______________________________ Claim Number: ______________________________

1. I, the undersigned, hereby referred to as “the patient” do hereby assign all of my rights and interest to **Neurology Group of Bergen County,** hereafter referred to as “the medical provider” to pursue and obtain payment from the above-mentioned insurance carrier. This assignment shall include, but is not limited to, all rights available to me pursuant to the Personal Injury Protection Statutes of the State of New Jersey.

2. I, irrevocably assign, to the medical provider, all my rights and benefits under the insurance contract for payment for services rendered to me.

3. I, the patient, do hereby understand and acknowledge that if I willfully refuse to comply with reasonable requests of the insurance carrier, payment of my medical bills may be denied and I will be held responsible for same.

4. I, the patient, authorized my bodily injury attorney and/or insurance carrier to pay directly to the medical provider any monies due on my account, or, the same to be deducted from any settlement made on my behalf.

5. I, the patient, do hereby acknowledge that I will not file suit and/or arbitration for the payment of the above provider’s medical bills. I understand that the above referenced medical provider has an attorney and will collect payment on my behalf from the insurance carrier.

6. The provider shall submit disputes to personal injury protection dispute arbitration if the decision point review plan requires same.

7. In the event it is determined by an Arbitrator and/or Court of Law that the imposition of a co-payment penalty was a result of the medical provider's failure to pre-certify treatment or comply with other decision point of review requirements, the provider will hold the patient harmless for such co-payment penalty.

8. In the event that insurance carrier and/or the vendor designated by the insurance carrier does not accept my assignment, or my assignment is challenged for being invalid, I execute this limited/special power of attorney and appoint an authorize the medical provider and counsel on behalf of the medical provider to file suit and/or arbitration directly against the carrier in my name and/or allow the medical provider to amend the lawsuit and/or arbitration to include my name.

Signature: _______________________________________ Date: ____ / ____ / ____

Patient Name: ____________________________________ Date: ____ / ____ / ____