PAVILION SPINE SURGERY CENTER
3193 Howell Mill Road, Suite 317
Atlanta, GA 30327
404.603.9090 (O) 404.603.9634 (F)

PATIENT NAME: _____ **DATE:** _____

PLEASE COMPLETE THE FOLLOWING INFORMATION:

Is your visit today related to a new injury or condition? _____ Yes _____ No

If yes, please indicate the cause of injury:

_____ **Motor Vehicle Accident** Date of Injury _____ State _____

Do you have Medpay available through your personal automobile insurance? _____*Yes _____ No
If yes, have you reported this accident to your personal auto insurance – Claim # _____

*Medpay is generally primary in the State of Georgia, over your health insurance and should be utilized before any health insurance. Once Medpay has been exhausted then your health insurance or attorney lien would be filed.

_____ **Work Related Accident** Date of Injury _____ State _____

Employer _____ Adjuster Name/Phone _____

_____ **Slip and Fall** Date of Injury _____

Location _____ City and State _____

_____ **Other** Please Explain _____

Have you retained the services of an attorney? _____ **Yes _____ No

If yes, please provide the following information: Name of Attorney: _____

Phone Number _____ Contact Person _____

We will require both you and your attorney sign an attorney lien. If a lien is not signed by both, you **WILL BE REQUIRED TO PAY ALL DEDUCTIBLES, CO-PAYS and CO-INSURANCES at time of service, **NO EXCEPTIONS!**

_____ _____
Signature of Patient (Legal Guardian) Date