



ORTHOPAEDIC MULTISPECIALTY NETWORK, INC

4760 Belpar Street NW * Canton, OH 44718 *
(330) 492-9200 * Fax (330) 492-5454

Name: _____

Birth Date: _____

Accident Date: _____

PATIENTS Auto / Accident Insurance:

Insurance carrier: _____

Billing Address: _____

Adjustor name: _____

Adjustor phone: _____

CLAIM NUMBER: _____

Brief description of the accident: _____

Is there an attorney involved? **YES** _____ **NO** _____

Attorney name: _____ Phone: _____

- I understand that I am financially responsible for any and all charges incurred by myself or my dependent for medical services.
- OMNI will submit claims to the patient's own insurance carrier as a courtesy. If payment is not received within 30 days, payment in full is due from the patient or guardian. **OMNI does not bill third parties, or hold accounts for settlement.**
- Charges may be submitted to my health insurance carrier with a valid subrogation agreement, but I remain personally liable to OMNI for all charges.
- I understand and agree that charges are due in full the same day as the visit unless my health insurance or first party insurance is being billed and I have a valid subrogation agreement with my health insurance company. I understand and agree that co-pays that my health insurance requires I pay are due the same day as the visit.
- I hereby authorize OMNI Orthopaedics to release any medical information necessary to process insurance claims. I certify that the above information is true and accurate to the best of my knowledge. I authorize and direct payment to OMNI Orthopaedics for surgical and medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for charges not paid by insurance or not covered by this agreement.

Signed: _____

(Patient or Responsible party)

Date: _____