Fowler Simmons RADIOLOGY

Fowler Simmons Radiology
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FINANCIAL CONSENT (MOTOR VEHICLE ACCIDENT)

PATIENT DETAILS

Family Name					
Given Name					
Address					
Suburb		State		Postcode	
Date of Birth	/ /	Phone	( )		
Email	@				

CLAIM DETAILS

Insurer			
Claim Number			
Date of Injury			
Case Manager's Name			
Phone	( )	Fax	( )
Email	@		

DECLARATION BY PATIENT:

If your examination is related to a MVA claim you must coordinate with the insurance company to get prior approval. Without written confirmation from the insurance, the account must be covered by the patient.

I agree to and accept financial responsibility for the cost of the procedures performed by Fowler Simmons Radiology. I understand and acknowledge that in the event that my insurance does not pay for the service(s) performed, it is my responsibility to cover the outstanding account.

I accept that Fowler Simmons Radiology may be required to exchange any relevant information (e.g. copy of radiology report, account enquiries) to your case manager.

Patient or Guardian's signature ________________________ Date / /

Patient or Guardian's name (Please Print) ________________________