

**IF ACCIDENT RELATED PLEASE COMPLETE**

Date of accident \_\_\_\_\_ Accident Details \_\_\_\_\_

Is this result of a motor vehicle accident? \_\_\_\_\_

Automobile insurance company name \_\_\_\_\_

Phone# \_\_\_\_\_ Address \_\_\_\_\_

Policyholder Name \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

**IF AN ON-THE-JOB INJURY, PLEASE COMPLETE**

Date of accident \_\_\_\_\_ Accident Details \_\_\_\_\_

Was the accident reported to your employer? \_\_\_\_\_ Date reported \_\_\_\_\_

Employer Name \_\_\_\_\_

Address \_\_\_\_\_

Phone# \_\_\_\_\_ Contact Person \_\_\_\_\_

Workers compensation insurance company name \_\_\_\_\_

Claims mailing address \_\_\_\_\_

Phone # \_\_\_\_\_ Case no. \_\_\_\_\_

If any other person(s), company or third party is responsible for the accident expenses,  
please indicate name, address and phone #.

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_

If legal matter, please give attorney's name, address and phone #.

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone # \_\_\_\_\_

**PLEASE PRESENT INSURANCE CARD(S) TO RECEPTIONIST FOR PHOTOCOPYING**

I authorize release of any medical information necessary to process this claim. I also authorize the direct payment of any benefits due to me for the described services to Hughes Eye Center, Retina Consultants, P.C., or VRF. I understand that I am financially responsible for paying any unpaid balance and will be responsible for the entire bill if claims are not covered by my insurance.

\_\_\_\_\_  
Patient or Legal Guardian Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date