



Scott A. Steingard, D.O.
Family Practice
Board Certified, A.O.B.F.P.
Sports Medicine-Manipulative Medicine
Sports Medicine-C.A.O., A.O.A.S.M.

Jason H. Turner, M.D.
Family Practice
Board Certified, A.B.F.P.

Milissa A. Cooper, D.O.
Family Practice
Board Certified, A.O.B.F.P.

Tiffany M. Tapia, MMS, PA-C
Board Certified

MEDICAL REPORTS & DOCTORS'S LIEN

Re: _____

Attorney _____

SS# _____

Paralegal _____

DOB _____

DOI _____

Phone# _____ Fax# _____

I do hereby authorize Steingard Medical Group, P.C. to furnish my attorney, with a full report of examination, diagnosis, treatment, prognosis, etc., of myself in regard to the accident in which I was involved in on _____.

I hereby authorize and direct my attorney, to pay directly to Steingard Medical Group, such sums as may be due and owing Steingard Medical Group, from all monies received which are intended, in whole or in part, as payment, reimbursement or compensation for medical services rendered. These funds shall include, but not be limited to, all group or private medical insurance payments, all automobile medical payments (med pay) funds, all worker's compensation medical expense payments, and all sums received through any settlement, judgement, verdict or arbitrator's award. I hereby further give an irrevocable lien in favor of said doctor on my claim for personal injuries and on all funds paid, from any source, as payment, reimbursement or compensation for medical services rendered.

I fully understand that I am directly and fully responsible to Steingard Medical Group for all medical bills submitted by them for services rendered to me and that this agreement is made solely for Steingard Medical Group's protection and in consideration of the doctor's awaiting payment. And I further understand that such payment is not contingent on any settlement, judgement or verdict by which I may eventually recover said fee.

Please acknowledge this letter by signing below. I have been advised that if my attorney does not wish to cooperate in protecting the doctor's interest, the doctor will not await payment but will require me to pay on my account and keep it on a current basis.

Dated _____

Patient's, Guardian's or Representative's Signature

Account# _____

Patient's Name (printed)

The undersigned being attorney of record for the above patient, does hereby agree to observe all the terms of the above and agrees to withhold such sums as may be necessary to adequately protect said doctor, from all monies received which are intended, in whole or in part, as payment, reimbursement or compensation for medical services rendered. These funds shall include, but not be limited to, all group or private medical insurance payments, all automobile medical payments (med pay) funds, all worker's compensation medical expense payments, and all sums received through any settlement, judgement, verdict or arbitrator's award.

Dated _____

Attorney's Signature



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ASSIGNMENT AUTHORIZATION, POWER OF ATTORNEY, AND AGREEMENT

In that this office is waiting for payment of its fees, I agree to provide the office with information and forms regarding any potential source of fee payment, to assist in any way I can, and

1. I hereby assign this office my rights to receive payments from insurance companies. Payments should be made directly to:

**Steingard Medical Group, P.C.
5830 N. 19th Avenue
Phoenix, Arizona 85015**

If my policy prohibits assignments, please make check payable to me and mail to the above address.

2. I understand that if this office receives more than their fees, the office will pay any credit balances to me, the patient.
3. I authorize the office to release any information to any insurance company, adjustor, agent, or attorney that will assist in payment of a claim.
4. I appoint this office as attorney-in-fact to correspond in my behalf with insurance companies, to negotiate any settlement, and to cash any settlement draft or check. Counsel, insurance companies, and negligent parties be advised that no settlement can be effectuated without the agreement of this office or the office's release of this specific provision.
5. A photocopy of this form shall be valid as the original.
6. I understand that health insurance company may not withhold benefits nor fail to process a valid claim by reason of the refusal to sign the "Right of Reimbursement" agreement. (See Allstate vs. Druke, 118 Arizona 301, 1978).
7. Please note-no fee adjustments will be made on Motor Vehicle accounts.

Insured or Authorized Signature

Date

Patient's Name (Printed)

Acct #



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MOTOR VEHICLE ACCIDENT POLICY

Date: _____

Name: _____

DOI: _____

Account #: _____

If you have been injured in an auto accident we can bill your health insurance, auto med pay policy (if available), the third party liability, and keep it on an attorney lien, provided, all of the required information is received from you on the first visit with the Steingard Medical Group. We will take attorney liens in good faith, however be advised that you are still financially responsible for the account and we will periodically need status of the case from yourself or your attorney. Please let us know immediately if there are any changes (address, phone number, attorney, insurance company, etc) so we may update our files and contact the necessary parties. As a reminder that your account is still open you will receive statements.

Your signature represents that you have read, understand and agree to this policy.

Patient's signature

Steingard Medical Group Representative

LIEN VERIFICATION FORM

Name: _____ DOB: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

SSN: _____ Alt. Phone: _____

Date of Injury: _____

Attorney Information:

Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Paralegal: _____ Fax: _____

Insurance Information: (Please list only if we are billing your health insurance)

Health Insurance Carrier: _____ Group: _____

ID#: _____ Insured: _____

DOB: _____ Relationship: _____

Ins. Phone: _____ Billing Address: _____

Auto Insurance Carrier: (Med Pay or Third Party) _____

Insured: _____ DOB: _____

Claim #: _____ Adjustor: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

All information must be presented at initial visit. Copy of police report, copies of insurance cards for both drivers, health insurance card(s) and Attorney's card with information.