Gerald Family Care, P.C.
Melvin D. Gerald, M.D., M.P.H., Founder *Family Practice*

De Paul Professional Building
1160 Varnum St. NE, STE #117
Washington, D.C. 20017
Ph: (202) 832- 7007

Glenarden Medical Center
7940 Johnson Avenue
Glenarden, MD 20706
Ph: (301) 364- 3200

PLEASE PRINT

MOTOR VEHICLE ACCIDENT INFORMATION

Date of Accident: _____ Claim Number: _____

Insurance Carrier: _____

Insurance Carrier's Address: _____
Street Address Suite Number

_____
City State Zip Code

Agent Handling Claim: _____ Telephone Number: _____

ATTORNEY INFORMATION: INDICATE IF NOT APPLICABLE (N/A)

Name of Attorney: _____

Address: _____
Street address Suite Number

_____
City State Zip Code

Phone Number _____

I acknowledge that the information I have provided here to Gerald Family Care, PC is complete and true to the best of my knowledge.

_____ _____ _____
Patient's Printed Name Patient's Signature Date

GERALD FAMILY CARE, P.C.

PAYMENT PLAN AGREEMENT

AUTHORIZATION AND ASSIGNMENT

You are hereby authorized to furnish to my attorney(s) any and all medical information, bills, and records which they may request in reference to all illnesses and injuries suffered by me or my children, including but not limited to, the injuries sustained on the date of accident identified below.

I further irrevocably assign to you, and authorize and direct my attorney(s) to pay from the proceeds of any settlement, judgment or insurance policy, all reasonable fees for health care services, equipment, supplies, preparation of reports, and testimony provided by you as a result of the injury or condition sustained on the date of accident. I understand that this in no way relieves me of my personal primary responsibility to pay for such services, and that the signing of this form does not prohibit customary billing by you. I further understand that my responsibility to you for payment is not contingent on any settlement, judgment or verdict.

I authorize any insurance carrier to pay directly to my physicians such sums as may be due and owing to them. If I directly receive any proceeds of any insurance policy, including but not limited to proceeds from any medical insurance, personal injury protection, and medical payment coverage, I agree to immediately make payment to you upon receipt of those monies.

It is further understood that the statute of limitations in this State is three (3) years from the time services were last performed. I further understand that because of long delays in trial dockets, many cases are not tried or settled until a date which is beyond the three (3) years after the last service was performed. In view of this, I hereby agree that the statute of limitations with respect to any claim for fees for services mentioned above will not begin to run until there is a denial in writing by me of any balance claimed to be due and owing to you by me.

I further authorize my attorney(s) upon your request to notify you of any substantial change in the status of the cause of action related to the illness or injuries described above which would affect my ability to pay for the health care services rendered. I further authorize and direct my attorney(s) to notify you should their representation of my interests in connection with the illnesses and injuries be terminated for any reason.

A photocopy of this Authorization shall be as binding as an original.

DATE OF ACCIDENT	PRINTED NAME	PATIENT'S SIGNATURE	DATE SIGNED
ADDRESS			STATE OF ACCIDENT

The undersigned attorney for the patient referred to above hereby agrees to comply fully with the foregoing "Authorization and Assignment" and agrees to advise (in writing) the named assignee, the physicians referred to above, of the status of the claim of the above named patient within ten (10) days of any request.

ATTORNEY NAME – PRINTED	ATTORNEY'S SIGNATURE	DATE SIGNED
ADDRESS		PHONE NO.