2930 Canal Street
Suite 301
New Orleans, La 70119
504-821-2574

ORTHOPEDIC APPROVAL

PATIENT INFORMTION

Patient Name: ________________________________ Male ☐ Female ☐

Date of Birth: _______________________ Phone :______-_______-______

Date of Accident: ____________________

Referring Physician**:** __________________

Diagnostics Tests performed (i.e. X-RAY, MRI, CT):

****PLEASE ATTACH WRITTEN REPORT OR LET US KNOW WHAT FACILITY WAS USED****

Test(s) Performed:____

Facility Information: ____

ATTORNEY INFORMATION:

Attorney: _______________________ Phone: _______-_______-________

Email: _________________________ Fax: _______-_______-________

(This email will be used to send all reports and bills)

A $400 Deposit is due before the initial office visits; **unless they are an in-network** patient (i.e. they have been treated with Metropolitan Health Group). Please note this will further guarantee payments of all accident-related medical charges out of the proceeds of any settlement funds received on the client’s behalf. If you agree with this, please sign and fax or email.

Is patient **in network**: _____

Please ensure to send the deposit, previous doctors records & diagnostic reports ***prior* to the visit. Otherwise it will cause delay in evaluation & treatment **

Direct Fax: 504-821-2573 **Email:** smartinez@lmmc.net

Attorney’s Signature ___________________________ Date:______________