F. ALLEN JOHNSTON, M.D.
— ORTHOPEDIC SURGERY —

· *Diplomate of the American Board of Orthopaedic Surgeons*
· *Diplomate of the American Academy of Disability Evaluating Physicians*

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: _____-_____-_____

Fax: _____-_____-_____

Email: _____

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

WORKER'S COMP INFORMATION:

Adjuster: _____

Claim #: _____

Company: _____

Phone: _____-_____-_____

Fax: _____-_____-_____

A $500 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: johnstonlmmc@gmail.com**

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Attorney's Signature _____ Date:_____