Diplomate of the American Board of Orthopaedic Surgery & the American Academy of Disability Evaluating Physicians

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ORTHOPEDIC APPROVAL

Patient: ______________________________ ☐ Female ☐ Male

Phone: ______________ Date of Injury: __________ DOB: __________

Referring Physician & Facility: ______________________________

List affected areas of the body to be evaluated & treated —

____

DIAGNOSTIC TESTING — *Attach all reports of previous imaging, scans, etc.*

Tests Performed: ______________________________

Facility & Location: ______________________________

ATTORNEY

Name: ______________________________

Firm: ______________________________

Phone: ______________________________

Fax: ______________________________

Email: ______________________________

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This email address will be used for all updates & correspondence.

WORKERS COMP

Claim #: ______________________________

Adjuster: ______________________________

Company: ______________________________

Phone: ______________________________

Fax: ______________________________

Other: ______________________________

An initial deposit of $500 is required via mail for all out-of-network patients.
This deposit is waived for patients already treating within our **Metropolitan Health Group** network.

This patient is: ☐ In Network ☐ Out of Network

Please return this **completed** form via email to **MMOTLEY@METROHEALTHGROUPLA.NET** or fax to our office.
Also send the physician's orthopedic referral, diagnostic reports, previous records, & a copy of the deposit check.

These documents must be received prior to scheduling the initial evaluation.

Attorney's Signature: ______________________________ **Date:** ______________

By signing this approval form, you are guaranteeing payment of all injury-related medical charges when your client's settlement is reached.