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

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

ORTHOPEDIC TREATMENT APPROVAL

Return this completed form via email to **MORGAN@LMMC.NET** or fax to (504) 821-2573.
Include the physician's referral, diagnostic reports, previous records & a copy of the deposit check.

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

PATIENT: ______________________ TEL: ______________

CHART #: __________ DOB: __________ DATE(S) OF INJURY: ______________

REFERRING PHYSICIAN / FACILITY: ______________________

AFFECTED AREAS OF THE BODY TO BE TREATED: ☐ *Address all injury-related complaints.*

____

ATTORNEY

NAME: ______________________

FIRM: ______________________

TEL: ______________________

FAX: ______________________

EMAIL:

____

The email address(es) listed above will be used for all updates & correspondence regarding this patient.

WORKERS COMP

CLAIM #: ______________________

COMPANY: ______________________

ADJUSTER: ______________________

ADJ TEL: ______________________

ADJ FAX: ______________________

OTHER:

____

An initial deposit of $500 is required for out-of-network patients. This deposit is waived for patients already treating within the **Metropolitan Health Group** network. This patient is:

☐ In Network ☐ Out of Network

To avoid delay or lapse in treatment, you may pre-authorize PT in-network at **Metropolitan Health Group**. If recommended, referrals will be sent directly to the patient's preferred location.

☐ Approve MHG Physical Therapy

ATTORNEY SIGNATURE: ______________________ **DATE:** ______________

By signing & submitting this form, you guarantee payment of all injury-related charges when your client's settlement is reached.

2930 CANAL STREET, SUITE 301, NEW ORLEANS, LA 70119

FACILITY MAIN: (504) 821-2574 | ORTHO DEPT: (504) 313-6153 | FAX: (504) 821-2573 | EMAIL: ORTHO@LMMC.NET