Family Care
ASSOCIATES
www.familycareassociates.com
1106 N Merchant Street
P.O.Box 665
Effingham, IL 62401
Ph: 217-342-7000 Fax: 217-342-7002

Notice of Claim of Lien for Medical Services

Notice is hereby given that Family Care Associates of Effingham, S.C.; a licensed health care provider, has performed services for _____.
(patient name and DOB)

Services were rendered and necessary to said patient as a result of injuries/illness which occurred at _____ on _____, through the fault of
(location) (date)
_____, whose address is _____,

phone_____, and who is insured by _____.

Company: _____

Agent:_____

Address:_____

Phone:_____

If you were in a motor vehicle accident, were you the driver or Passenger? _____

I do hereby authorize Family Care Associates of Effingham, S.C. to provide you, my attorney/insurance carrier, with a full report of this case history, examination, diagnosis, treatment, and prognosis of myself in regard to my accident/illness.

I hereby give a lien to this practice on any settlement, claim, judgment, or verdict as a result of said accident/illness and authorize and direct you, my attorney/insurance carrier, to pay directly to said practice such sums as may be due and owing him for services rendered me and to withhold sums from such settlement, claim, judgment, or verdict as may be necessary to protect said practice adequately.

I fully understand that I am directly and fully responsible to said practice for all medical bills submitted for service rendered to me and that this agreement is made solely for said practice's additional protection and in consideration of future payment. I further understand that such payment is not contingent on any settlement, claim, judgment, or verdict by which I may eventually recover said fee.

Name_____ DOB _____

Signature_____ Date_____

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Liability Insurance

In order to ensure timely payment of liability claims, we require all of the following information to be completed accurately. Failure to provide all of the necessary information may result in claim denials and ultimately patient financial responsibility. Please take time to complete this form before your visit to Family Care Associates.

Auto Insurance Policy (Self):
Policy/Claim Number_____
Date of Accident/Loss_____
Insurance Carrier_____
Agent Name_____
Phone Number_____

Auto Insurance (Third Party):
Policy/Claim Number_____
Date of Accident/Loss_____
Insurance Carrier_____
Agent Name_____
Phone Number_____

Primary Health Insurance:
Policy Number_____
Group Number_____
Insurance Carrier_____
Subscriber Name_____

Secondary Health Insurance:
Policy Number_____
Group Number_____
Insurance Carrier_____
Subscriber Name_____

It is our policy to bill the auto insurance for all claims related to an open motor vehicle accident case. If the auto policy fails to remit payment within 60 days from the date of service, or indicates no payment is forthcoming, we will bill your private health insurance plan. You will be responsible for any applicable deductibles or copays not covered by your health plan. Third party insurance information is collected for reporting purposes only.

☐ Do not bill my auto policy for services related to my motor vehicle accident. Please send all bills to my private health insurance plan. I agree to pay any applicable deductible, copay, or non-covered service fees within 30 days of benefit determination.

I attest that all of the information stated above is accurate and complete. I understand I may be responsible for any unpaid balances remaining after 90 days from the date of service. I am aware that my auto company may eventually remit payment and I may be reimbursed once a settlement has been reached.

_____ _____
Print Signature

Date_____