



Fondren Orthopedic Group L.L.P.

Patient Name: _____ Insurance Company: _____
SSN: _____ Provider Number: 087

Important Notice

Effective September 1, 2003, the following physicians are non-participating physicians in the Texas Workers' Compensation Program. Therefore, they are not listed as part of the ADL (Approved Doctor List) of the TWCC (Texas Workers' Compensation Commission) and are not authorized in any capacity to treat patients for any work-related injury under the Texas Workers' Compensation Commission system.

Non-ADL Physicians

Gary T. Brock, M.D.
Howard R. Epps, M.D.
Richard J. Kearns, M.D.

Robert L. Burke, M.D.
Gary M. Gartsman, M.D.
Gregory W. Hanson, M.D.

According to Texas Labor Code § 413.042 the patient is responsible for ALL healthcare expenses incurred if he or she violates Texas Labor Code § 408.022 relating to the selection of a doctor and receives medical treatment from a physician NOT chosen from a list of doctors approved by the commission.

Patient Certification: I hereby certify that the information provided by me is truthful, accurate and correct. I fully understand the above mentioned state law as well as any related regulations.

I have read and understand the above statement regarding WORKERS' COMPENSATION BENEFITS coverage.

[] This is a work-related condition, injury or symptom.

[] This is NOT a work-related condition, injury or symptom.

I am scheduled to see Doctor: LONCARICH

Financial Obligation: I understand if the information I provide is inaccurate, Fondren Orthopedic Group L.L.P., may not be able to collect payment from my Insurance Company. I also understand and acknowledge that providing false information on the completed forms will result in serious legal consequences for myself.

I hereby affirm that I am responsible to pay Fondren Orthopedic Group L.L.P., on demand for my medical services if I violated Texas law and knowingly selected a physician not chosen from a list of doctors approved by the Texas Workers' Compensation Commission. Further, I understand that I will be financially liable if my Insurance Company declares the services to be work-related resulting in a request for refund, if I do not dispute the issue to declare it otherwise.

Printed Name: _____

Signature: _____
Patient Date Witness Date