WORKERS COMPENSATION / OCCUPATIONAL MEDICINE FORM

□ New Patient □ Established Patient

Patient Name:		
Date of Birth:	Social Security #:	

EMPLOYER INFORMATION

Employer Name:		
Address:		
City:	State:	Zip:
Telephone #:	Fax #:	
Supervisor/Contact Name:	Email:	

WORKERS COMPENSATION CARRIER INFORMATION

Workers Compensation Carrier:		
Policy #:	Claim #:	
Address:		
City:	State:	Zip:
Telephone #:	Fax #:	
Date of Injury:	**Time of Injury:**	

AUTHORIZATION TO TREAT AND BILL

This authorization covers all services rendered to the above patient for today and all future dates of service. I may submit a written revocation of the authorization; however, my decision to revoke will not affect or undo any events that occurred before I notified you. I give consent for the above named patient to be treated. I authorize the release of any information necessary to process all claims as an occupational or worker's compensation claim. I understand that if my claim is denied, I will be responsible for all charges incurred for all services rendered. I also understand that my medical and claim information regarding my injury/illness/care will be shared with the insurance carrier, the industrial commission and/or my employer.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

This acknowledgement covers all services rendered to the above patient for today and all future dates of service. I may submit a written revocation of the authorization; however, my decision to revoke will not affect or undo any events that occurred before I notified you. We reserve the right to modify the privacy practices outlined in the Notice of Privacy Practices. I have received a copy of the Notice of Privacy Practices.

SIGNATURE

Patient/Guardian Name *(please print)*:	Date:
Signature:	