Park Central Family Practice, Inc.

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WORKER'S COMPENSATION AUTHORIZATION FORM

Patient's Name________________________ Date Of Injury____________________

Type Of Injury________________________ Company Name_______________________

Contact Person________________________ Telephone Number_________________

Worker's Comp Carrier Name___________________ Telephone Number__________________

Adjuster's Name__________________________ Claim #____________________________

Where are claims to be filed (employer or carrier) How may we identify your employee?

Name:_______________________________ Photo ID______

Address:_____________________________ Other verification____________

City: _______________________________

Is a drug screen required ? Yes____No____ If yes what type_______________

Has employer filed first report of injury? Yes____ No_____

Instructions for our office (how do you require us work with you?)

Do you authorize?

____Initial visit only

____Initial Visit and Treatment

____Initial Evaluation, Treatment and Follow Up Visits

Should we call you before or after each visit ?

Do you require a status report with each visit? ____Yes _____No

This certifies that the above information is correct. I authorize the medical provider to provide medical treatment to the employee name above.

Signature ______________________________ Position/ Title_______________________

Please Print Name___________________________ Date_________________________________