

WORKERS' COMPENSATION AUTHORIZATION

PATIENT NAME _____

DATE _____

EMPLOYER _____

ADDRESS & HR CONTACT _____

PHONE # _____

SUPERVISOR _____

EMPLOYEE _____

DATE OF ACCIDENT _____

INSURANCE CARRIER _____

ADDRESS & PHONE # _____

CLAIM # _____

ADJUSTER/AGENT _____

AUTHORIZED BY PHONE _____ **SPOKE WITH** _____

SPECIFIC INSTRUCTIONS _____

The above patient reported to our office for examination and chiropractic treatment due to injuries sustained while on the job. Please sign and return this authorization for treatment to our office AND submit a copy of the completed EMPLOYEE'S INJURY REPORT. If for any reason Insurance does not pay, the patient is fully responsible for the unpaid balance. Thank you for your assistance.

Signature

Title

NOTE: According to L.C. Section 4600, the employer is required to inform all injured employees of their rights and benefits with respect to medical/chiropractic treatment.