PLEASE SEND OR FAX COMPLETED FORM WITH EACH EMPLOYEE YOU SEND TO OUR OFFICE.
WE MUST HAVE THIS ON FILE BEFORE WE CAN SEE YOUR EMPLOYEE!!!!

723 HILL COUNTRY DRIVE SUITE C
KERRVILLE, TEXAS 78028
PHONE: 830-792-5800
FAX: 830-896-2625
frontoffice@franklinclinic.net

AUTHORIZATION FORM

COMPANY NAME: _____ PHONE: _____

ADDRESS: _____ FAX: _____

TWCC SUBCRIBER: YES _____ NO _____ TAX ID: _____

PATIENT NAME: _____DATE OF INJURY: _____

DOB: _____ SOCIAL SECURITY: _____

_____ Company will be paying for services not related to Workers Comp _____ Initial

_____ **I DO NOT HAVE WORKERS COMP INSURANCE THE COMPANY WILL BE PAYING FOR THE SERVICES. Please send bill to address above. _____Initial**

_____ I DO HAVE WORKERS COMP INSURANCE. **PLEASE FILL OUT THE INFOMRATION IN ITS ENTIRETY**.

FORMS THAT ARE NOT COMPLETED WILL BE RETURNED AND WILL PROLONG THE PATIENT FROM BEING SEEN!

WORKERS COMP INSURANCE NAME: _____

PHONE: _____ FAX: _____

ADDRESS: _____ STATE/ZIP: _____

CLAIM NUMBER: _____ CASE WORKER'S NAME: _____

DRUG SCREENING: URINE ONLY, VALID GOVERNMENT ISSUED PHOTO ID REQUIRED. NO EXCEPTIONS
WE DO NOT COLLECT FOR **FEDERAL DOT DRUG SCREENINGS**:

DRUG SCREEN:	**PHYSICALS:**	**OTHER:**
_____ No Drug Screen Needed	_____ DOT	_____ X-RAY
_____ RANDOM	_____ BASIC EXAM (NON DOT)	_____ TB SKIN TEST
_____ POST ACCIDENT	_____ WORK-COMP INJURY	_____ COVID TEST
_____ PRE-EMPLOYMENT	_____ PRE-EMPLOYMENT	_____ CALL FOR ADDITIONAL SERVICES

_____ Confirmation Testing for positive drug screen (additional fees apply).

I AUTHORIZE TREATMENT AND PAYMENT FOR SERVICES:

AUTHORIZED BY (PRINT NAME) _____

SIGNATURE: _____ DATE: _____