

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 SUBSCRIBER: YES \_\_\_\_\_ NO \_\_\_\_\_ TAX ID: \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_ DATE OF INJURY: \_\_\_\_\_

DOB: \_\_\_\_\_ SOCIAL SECURITY: \_\_\_\_\_

\_\_\_\_\_ 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 INFORMATION IN ITS ENTIRETY.

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

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:**

<b>DRUG SCREEN:</b>	<b>PHYSICALS:</b>	<b>OTHER:</b>
_____ RANDOM	_____ DOT	_____ X-RAY
_____ POST ACCIDENT	_____ BASIC EXAM (NON DOT)	_____ TB SKIN TEST
_____ PRE-EMPLOYMENT	_____ OTHER	

**I AUTHORIZE TREATMENT AND PAYMENT FOR SERVICES:**

AUTHORIZED BY (PRINT NAME) \_\_\_\_\_

SIGNATURE: \_\_\_\_\_

**NOTICE!** If an employee has had a positive TB/PPD skin test in the past, they will be asked to provide proof of "TRUE POSITIVE TB/PPD skin test" in order to bypass a skin test and receive a chest x-ray. If they are not able to provide proof they will be required to see a provider prior to receiving a chest x-ray, even if they have been seen in our office in the last 3 years.

10/02/2018