

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: _____

_____ 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 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:**

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

I AUTHORIZE TREATMENT AND PAYMENT FOR SERVICES:

AUTHORIZED BY (PRINT NAME) _____

SIGNATURE: _____ DATE: _____

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.

12/02/2020