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!!!!

Franklin Clinic

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: _____

☐ **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!

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	_____ OTHER	
☐ PRE-EMPLOYMENT		

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