THIS FORM MUST BE **COMPLETED IN FULL** BY AN AUTHORIZED MEMBER OF YOUR HUMAN RESOURCES DEPARTMENT AND RETUNRED TO US **PRIOR** TO YOUR APPOINTMENT.

Hermitage Family Practice
244 Jackson Meadows Dr
Hermitage, TN 37076
PHONE: 615-874-9888 FAX: 615-883-6899

DATE:

Patient Name: Date of Birth: SS#

Patient Home Address:

City: State: Zip:

Patient Phone Number:

Date of Work Related Accident/Injury: Nature of Injury:

Employer Name: Supervisor/HR Contact:

Employer Address:

City: State: Zip:

Employer Phone Number: Employer Fax Number:

Worker's Compensation Insurance Carrier:

Insurance Address:

City: State: Zip:

Insurance Phone Number: Insurance Fax Number:

Insurance Contact:

Does treatment, including referral to a specialist or laboratory/radiology testing, need to be pre-approved? _____

Is there a limit on the number of visits to our office? Do we need to get approval for each visit? _____

Do we need to fax office notes to anyone other than the insurance company? _____ If yes, who? _____

By signing this form, I am authorizing treatment of the above named individual for a work related accident/injury and understand that my company is ultimately responsible for payment on these services.

_____ _____ _____

Signature of Person Giving Authorization Print Name Title/Extension(if needed)