WEST TENNESSEE
BONE & JOINT
INSTITUTE
EST. 1973

# Employer Authorization Form

## Patient must present Photo ID and Authorization Form at time of service

| SECTION I: | Patient Information | | |
|---|---|---|---|
| Last Name: | | First Name: | |
| Date of Birth: | | SSN: | |

| SECTION II: | Company Information | | | | |
|---|---|---|---|---|---|
| Employer Name: | | | | Primary Contact: | |
| Phone Number: | | Email: | | Address: | |

**SECTION III: Appointment Type**

☐ Urgent Care: Walk In Appointment ☐ Scheduling Future Appointment

**Employer is a participant of the Federal Drug Free Work Force program: ☐ Yes (Program requires lab based UDS) No: ☐**

**If no, will a drug screen need to be preformed? ☐ Yes ☐ No**

**SECTION IV: WORKERS ' COMPENSATION**

☐ Workers' Compensation Injury Treatment

Date of Injury: _____ Type of Injury : _____

W/C Authorization Number : _____

Where are the claims to be filed? ☐ Bill Employer ☐ Insurance Carrier

W/C Carrier Name : _____

W/C Carrier Address: _____

W/C Carrier Phone : _____ W/C Carrier Fax : _____ Policy Number: _____

**SECTION V: Customer Acknowledgement**

**Employer:** This certifies that the above information is correct. I authorize the medical provider to provider medical treatment to the employee names above. I also understand that the services provided will be paid in full by the company listerd above and authorized by my signature.

**X** _____ _____ _____

**Employer Authorized Signature (Required)** **Date** **Employer Printed Name (Required)**

_____

**Title**