Rincon Medical Urgent Care Center-Worker's Compensation

Please Print

Date: _____/_____/_____

Patient's Name:_____

(First) (Middle) (Last)

Social Security Number: _____-_____-_____ **Gender**: ☐ Male ☐Female **DOB**:_____/_____/_____ **Age**:_____

Employee Address:_____

City:_____ **State**:_____ **Zip**_____

Home Phone: (_____)_____ **Cell Phone**: (_____)_____ **Work Phone** (_____)_____

Please complete if the patient is under the age of 18

Parent/ Guardian Name_____

(First) (Middle) (Last)

Patient address if different from above: _____

City: _____ **State**: _____ **Zip**: _____

Home Phone (_____)_____ **Cell Phone** (____)_____ **Work Phone** (_____)_____

Employer Name_____

Employer Address_____

City _____ **State**:_____ **Zip**:_____

Worker's Compensation Contact:_____

Contact's Phone (____)_____Fax(_____)_____

The signature below serves as authorization for medical treatment by the physician, physician assistant or nurse. It also provides authorization to **Rincon Medical Center** to furnish and/or release any information necessary to insurance carrier, third party administration, and or health benefit payor representatives in order to process health care claims. This authorization also serves as permission to release my medical records to my designated primary care physician's office to ensure continuity of care. I understand that I may withdraw this authorization to release medical information at any time, when I communicate in writing. I acknowledge that **Rincon Medical Center** will file the insurance as a courtesy, but it is my responsibility to understand the insurance coverage. I understand that I am financially responsible for balances not covered by the worker's compensation insurance carrier.

Patient/Responsible Party Signature_____ **Date**:_____/_____/_____