Workers Compensation

University Walk In Medical Center
11550 University Blvd.
Orlando, Fl 32817
(407) 282-2044

Patient

Last Name		Date of Birth		Sex	Home Phone #
First Name M.I.		Social Security#			Cell Phone #
Street Address	Apt #	City		State	Zip / Marital Status
Employer *Or* College Name	City	State		Zip	Work Phone #
Primary Care Physician		City		State	Phone #

Employer

Company Name				
Company Contact	Contact Phone #		Contact Cell Phone # *(if known)*	
Street Address	Suite #	City	State	Zip

Details

How your accident happened	Date of Injury

Insurance

Work Comp Insurance Name	Claim #
Claims address	
Insurance Contact Name	Contact Phone #

Over 18

I would like to designate the following person as authorized to discuss my Personal Health Information, including diagnosis and treatment plans, with the UWMC office staff. This authorization remains in force until further written notice from the patient.

Authorized Persons Full Name	Authorized Persons BirthDate	Relationship to Patient

Are you interested in information about Living Wills? *(circle answer)*

a. Not at this time b. Yes, provide me info c. I currently have one (please provide copy to our office)

I authorize the physician to administer treatment, as he/she deems advisable for my diagnosis and treatment. I understand that these services are voluntary and I have the right to refuse them. Patient or guardian are responsible for charges incurred that are denied by the employers work comp carrier as non-compensable. Your employer's work comp carrier does not guarantee payment and neither does our office. All claims are subject to investigation by your work comp carrier.

A copy of our "Notice of Privacy Practices" is posted in our lobby. This notice informs you how we may use and/or disclose your health information. You may request a personal copy of this notice at any time from our staff.

By signing below you are acknowledging the above policies and procedures. This acknowledgement will be in force upon signature. This acknowledgement will remain in force until UWMC receives written notification from the patient revoking it.

Patient or Guardian Signature	Patient or Guardian Printed Name	Date