MARTINEZ URGENT CARE
210 BOBBY JONES EXPRESSWAY
MARTINEZ, GEORGIA 30907
(706) 855-1755
(706) 863-2587 (fax)

Company Demographics

Company Name:_____ Employee's Name:_____
Company Address:_____City:_____
State:_____Zip Code:_____Phone:_____Fax:_____
Point of Contact for Company:_____
Phone:_____Ext:_____Email:_____

Company Preferences:

Will we be conducting a drug screen today:_____How would you like the results reported:_____
*******If yes which type of drug screen: Instant:_____ Non DOT _____ DOT_____*******
Who will be paying for the drug screen: Company:_____Insurer_____
Will you be requesting a copy of medical records:_____How would you like to receive records_____
If the employee is referred to a specialist do you have a specified panel: Yes_____No_____
Physicians on panel: _____, _____,
_____, _____,

Workers Compensation Claim/Billing Information

Company's Workers Compensation Insurance:_____
Workers Compensation Insurance Address:_____
City_____State:_____Zip Code:_____Phone:_____
Workers Compensation Claim\Reference Number:_____
Date Injury was Reported:_____Time:_____Report by:_____
Name/title of who is authorizing medical treatment:_____
Signature:_____Date_____

****If company is choosing to pay for services instead of filing with their insurer:****

Responsible party for payment:_____
Person authorizing billing agreement:_____Phone:_____
Signature:_____Date:_____
Address for billing statement:_____
City:_____State:_____Zip Code:_____
Would you like to prepay for services:_____

AS THE EMPLOYER I _____ AKNOWLEDGE THAT IT IS MY RESPONSIBILITY TO SUBMIT ALL NECESSARY WORKERS COMPENSATION DOCUMENTS TO ENSURE TIMELY PAYMENT OF MY EMPLOYEE'S AUTHORIZED MEDICAL TREATMENT .

_____AGREES TO FURNISH PAYMENT TO MARTINEZ URGENT CARE FOR AUTHORIZED SERVICES RENDERED TO MY EMPLOYEE WITHIN 30 DAYS OF RECEIPT OF BILL, AS MANDATED BY GEORGIA STATE WORKERS COMPENSATION, O.C.G.A. 34-9-203.

Signature of Authorized Employer:_____Date:_____

Please fax this completed form to **(706) 863-2587** or E-mail to **martinezurgentcare@hotmail.com**

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EMPLOYEE Demographics

Name:_____

Address:_____City:_____

State:_____Zip:_____Phone_____Date of Birth_____SSN:_____

Place of Employment:_____

Company Address:_____City:_____
State:_____Zip Code:_____Phone:_____Fax:_____

Immediate Supervisor:_____Number:_____

Who authorized today's visit:_____

Injury

Date:_____Time:_____Location:_____

How Injury Occurred:_____

_____

_____

_____

_____

Did anyone witness the injury_____Who_____

EMPLOYEE Health History

Prior medical conditions that may be related to injury:_____

_____

Prior medical conditions that may have caused current injury:_____

_____

List of any surgeries near injury site:_____

Current medications:_____

_____

Medication allergies:_____

Known allergies:_____

NOTICE:

*If your injury is found to not be work related, and payment for medical treatment is denied by your employer , you will be held liable for any charges accrued.

*According to Workers Compensation Laws and Statues, we are required to comply with request from your employer and workers compensation insurer regarding your current medical records that are associated with your claim including drug screen results.

I _____have read over and completed this entire form to the best of my knowledge.

Signature_____Date:_____

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