MD NOW URGENT CARE

WORKERS' COMPENSATION REGISTRATION FORM

Patient Information:

Today's date	Chief Complaint (Symptoms)	Last Name, First, Mi.	Date of Birth:

Social Security: ___ ___ ___ - ___ ___ - ___ ___ ___ ___ | Email:

Mailing / Billing Address: | Apt/Unit #

City | State | Zip

Home Phone: (____) _____ - _____
Okay to leave voice message? ☐ YES ☐ NO

Cell Phone: (____) _____ - _____
Okay to leave voice message? ☐ YES ☐ NO

Sex	Race	Ethnicity	Language	Marital Status
☐ Male ☐ Female	☐ White ☐ Other ☐ Asian ☐ African American	☐ Hispanic / Latin ☐ Not Hispanic / Latin	☐ English ☐ Other ☐ Spanish ☐ Creole	☐ Single ☐ Separated ☐ Divorced ☐ Married ☐ Partner ☐ Widowed

Employer Information

Supervisor/Authorizing Person:

Email: | Company Name

Address

City | State | Zip

Direct Phone Number: (____) _____ - _____ | Fax Number: (____) _____ - _____

WAS THE INJURY REPORTED TO YOUR EMPLOYER? ☐ YES ☐ NO

Injury Information:

Date of Injury	Time of Injury	Injury (Body Part)

Description of how accident happened

Have you been treated for this injury by another facility? (Ex: ER, Urgent Care, Primary Care, etc.) ☐ Yes ☐ No, If yes, list below

Facility Name: | Phone: (____) _____ - _____ | Fax: (____) _____ - _____

Any previous Workers' Compensation Claims? ☐ Yes ☐ No, If yes, list below

Patient Preference Regarding Emergency Contact/Communication of Medical Information

I hereby **give permission to disclose and discuss** any information related to **my medical condition(s)** with the following family member, relative, or other person:

NAME	*RELATIONSHIP*	*PHONE NUMBER*

Financial and Medical Record Authorization:

Financial: I clearly understand and agree that I am personally responsible for payment of all services rendered to me in the event that my Workers' Compensation injury is not reported to my employer within 30 days of the date of injury. I understand that if I fail to report the injury to my employer within 30 days (required by law), I may be deemed responsible for all services rendered. I acknowledge that reporting my Workers' Compensation injury does not relieve me from my financial responsibility, resulting from a denial of my claim/case by the Workers' Compensation Carrier/Insurer for any given reason, and that ultimately I am responsible for payments.

Medical Record: I clearly understand that MD Now may request any and all of my medical records pertaining to this injury. By signing this document, I authorize MD Now to request and review any pertinent medical information from providers/facilities involved in treatment for my injury/injuries.

Patient Signature, Guardian, Personal Representative | Date

MD NOW URGENT CARE

(NON CORP) EMPLOYER AUTHORIZATION FOR SERVICES

To be Completed by Front Desk Staff and Signed by Authorizing Employer

(COMPLETE & FAX TO EMPLOYER)

Company Name & Number (Employer):	
Authorized By/Title:	
Direct Phone Number & Email:	
Where and to Whom do we fax DWC-25/light duty restrictions?	
Patient (Employee) Name:	
Date of Birth:	
Social Security Number:	

Has This Claim Been Reported? ☐**Yes** ☐**No** *440.185(2), F.S Within 7 days after actual knowledge of injury or death, the employer shall report such injury or death to its carrier, in a format prescribed by the department, and shall provide a copy of such report to the employee or the employee's estate.*

Is a Drug Screen Required? ☐ **Yes** ☐ **No**
(If employer states, "I do not know" ask if they're a FL Drug Free Workplace. If yes, default to 5 panel)

Is this a Post Accident Drug Screen? ☐ **Yes** ☐ **No**
Has the Patient been given a Chain of Custody Form? ☐ **Yes** ☐ **No**

☐ **5 Panel** ☐ **7 Panel** ☐ **10 Panel** ☐ **DOT Federal**
☐ **Breath Alcohol Test** ☐ **Drug Screen-Hair Collection**

Work Comp Insurance Carrier Nm & Address:	**Date of Injury:**
Adjuster Nm, Ph & Fax (If known):	**Claim Number (NOT POLICY NUMBER):**

Are Medications to be Dispensed at MD Now? ☐**Yes** ☐**No** *(DO NOT dispense for USDOL/CompOptions/York)*

EMPLOYER SECTION

Are you interested in one of our representatives contacting you to set up a Corporate Account: ☐ Yes ☐ No
***This is a free service and used simply to expedite your employees' registration process and to avoid any errors that may occur.*
Notes: _____

EMPLOYER AUTHORIZATION: I authorize the above services and understand that my company will be responsible for all services not covered by my Worker's Compensation carrier, including Post-Accident drug screens and breath alcohol tests. I understand that if a claim number is not provided to MD Now Urgent Care Medical Centers, Inc. in order for them to submit to my Worker's Compensation carrier, that I will be responsible for payment for the treatment of this employee.

Signature of Authorizing Company Supervisor:_____ **Date:**_____