



University Walk-In Medical Center, Inc  
 11550 University Blvd  
 Orlando, FL 32817  
 407-282-2044

Workers Compensation

<b>PATIENT</b>	Last Name		Date of Birth		Sex	Home Phone #		
	First Name		MI	Social Security # (required )		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 #	

<b>EMPLOYER</b>	Company Name						
	Company Contact			Contact Phone #		Contact Cell Phone # (if known)	
	Street Address			Suite #	City	State	Zip

<b>DETAILS</b>	How your accident happened				Date of injury		

<b>INSURANCE</b>	Primary Insurance Company			Subscriber's ID/Policy #		Group #	
	Subscriber's FULL Name			Date of Birth (required)	Employer	Relationship to Patient	
	Subscriber's Street Address			Apt#	City	State	Zip
	Secondary Insurance Company			Subscriber's ID/Policy #		Group #	
	Subscriber's FULL Name			Date of Birth	Employer	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)

<b>OVER18</b>	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

I authorized 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 is 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 company carrier.

A copy of our "Notice of Privacy Practices" is posted on our lobby. This notice informs you how we may use and/or disclose your health information. You may request a personal coy 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.

Parent or Guardian Signature	Patient or Guardian Printed Name	Date
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