Family Medical Clinic of North Mississippi, Inc
662-890-5555
662-890-8899 (fax)

Patient Name:_____ DOB:_____

ACCIDENT/WORK RELATED INJURY TREATMENT AUTHORIZATION:

1. Patient agrees to be financially responsible for the charges incurred at clinic. Clinic will not file a claim with patient's health insurance if the reason for the clinic visit is work related. Clinic may agree to file a claim with patients' insurance if the nature of an injury/accident is unclear at time of service. The patient is ultimately responsible for charges incurred at time of service.

_____ _____
Patient (Guarantor) Date

2. Family Medical Clinic of North Mississippi, Inc may allow a patient to charge a work-related visit to their company contingent upon following:

A. Signature of an authorized official of the company agreeing to remit payment for charges incurred by patient at the clinic.
B. Payment must be remitted within 30-days of date charges incurred.
C. Clinic will provide the company with a copy of an approved HCFA billing form and other documentation required in accordance with the Mississippi State Workers Compensation Commission.
D. Company agrees to the fee schedule established by clinic. The clinic will honor only contractual adjustments to fees based on the most recent Mississippi State Workers Compensation Fee Schedule.
E. Clinic will file claims directly to the company's workers compensation carrier if requested, however the company/patient will remain responsible for payment.
F. Company agrees not to request that the clinic alter its plan of care and/or recommendations for the patient's treatment.

_____ _____
Authorized Company Official Date

_____
Printed Name

_____ _____
Company Name Work. Comp. Carrier(if applicable)

_____ _____
Address Address

_____ _____

_____ _____

_____ _____