optimorthopedics

WorkComp@OptimOrthopedics.com

# WORKER'S COMPENSATION

## AUTHORIZATION AND INJURY TREATMENT FORM

**SUBMISSION OF THIS FORM WILL BE CONSIDERED AS AUTHORIZATION TO SCHEDULE AND TREAT FOR THE REFERENCED PATIENT AND INJURY(S)**
*Missing information can delay the scheduling process as all information is needed for scheduling and billing purposes. Please contact the Workers Compensation Team directly for further information.*

## BODY PART AFFECTED

- ☐ Elbow
- ☐ Foot / Ankle
- ☐ Hand / Upper Extremity
- ☐ Hip
- ☐ Knee
- ☐ Neck / Spine
- ☐ Shoulder
- ☐ Other (specify)_____

## PREFERRED PHYSICIAN

### FOOT & ANKLE
- ☐ Jeffrey Goldberg, MD
- ☐ Juha Jaakkola, MD
- ☐ Christopher Nicholson, MD

### GENERAL ORTHOPEDICS
- ☐ Jay Cook, MD
- ☐ Mark Kamaleson, MD

### HAND, WRIST & ELBOW
- ☐ John Burke, MD
- ☐ Michael Dunn, MD
- ☐ Travis Farmer, MD
- ☐ Gregory Kolovich, MD

### ORTHOPEDIC SPINE
- ☐ Thomas Lawhorne, MD
- ☐ John McCormick, MD
- ☐ Thomas Niemeier, MD

### SPORTS MED/ GENERAL ORTHO
- ☐ Don Aaron, MD
- ☐ Thomas Alexander, MD
- ☐ Jay Cook, MD
- ☐ Delan Gaines, MD
- ☐ David Palmer, MD
- ☐ David Sedory, MD
- ☐ Amir Shahien, MD
- ☐ Wesley Stroud, MD
- ☐ James Wilson, Jr, MD
- ☐ George Sutherland, MD
- ☐ Chad Zehms, MD

### ☐ TOTAL JOINT
- ☐ Kevin Brooks, MD
- ☐ Jonathan Christy, MD
- ☐ Jordan Paynter, MD
- Robert Shelley Jr, MD

### NON-OPERATIVE SPORTS MED
- ☐ Justin Lancaster, MD

### NO PREFERENCE
- ☐ No Physician Preference

## PATIENT INFORMATION

Patient Name (First, Middle, Last) _____

Home Address _____

City _____ State _____ Zip _____ Phone _____

DOB _____

Patient Mobile _____

Patient Email _____

Preferred Location _____
*(if blank, we will schedule at the earliest location available)*

## EMPLOYER INFORMATION

Employer Name _____

Address _____

City _____ State _____ Zip _____

Authorized By _____ Title _____

Email _____

Phone _____ Fax _____

Signature of Authorizing Party _____

## EMPLOYERS INSURANCE CARRIER

Work Comp Insurance Carrier _____

Claim # _____ Adjuster Information _____

Billing Address: _____

Email _____

Phone _____ Fax _____

## INJURY DETAILS

Type of Injury _____ Date of Injury _____

Injured Body Part _____ Affected Side: Left | Right | Multiple | N/A

Notes _____

**Please be aware that a self pay charge will appear on your account until your workers' compensation authorization is received from your employer or insurer. You will not be asked to pay this fee unless the claim is denied. By signing below, you acknowledge that you understand and agree to the above information.**

**Signature**_____ **Date:**_____

## DIRECT WORKCOMP SCHEDULING - PLEASE CALL

| *WORK COMP SAVANNAH* | *URGENT CARE DAYTIME* | *URGENT CARE EVENINGS* |
|---|---|---|
| ***912.644.5384*** | ***912-486-2382*** | ***912.651.8823*** |

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