LAKE OCONEE
URGENT & SPECIALTY
CARE CENTER

Worker's Comp Registration

Patient Last Name ______________________________ First Name __________________________ M.I. _____

Date of Birth______________________ Social Security ___________________________ ❒Male ❒Female

Home Telephone _______________________ Alternate Telephone _____________________ ❒Cell ❒Work

Street Address _____________________________ City ____________________ State________Zip __________

Emergency Contact _____________________________________ Relationship __________________________

Primary Care Physician __________________________________ Physician Phone _______________________

How did you hear about Lake Oconee Urgent & Specialty Care reserves? **❒Been Here Before**

❒Drive-By ❒Internet ❒Mailer ❒Around Town ❒Newspaper ❒Neighbor

❒Family/Friend ❒Physician Referral ❒Employer ❒Yellow Pages ❒Other _______________________

Date of Injury or Illness ____________________ Brief Description __________________________________

Has your employer been notified of this accident/injury? ❑ YES ❑ NO If YES; when? _______________

Has a claim been filed for this incident? ❑ YES ❑ NO If YES; what is the claim number? _______________

Place of Employment ________________________ Address ____

Employment Contact ____________________________ Contact Telephone ____________________________

Billing Company _______________________ Contact __________________ Telephone ____________________

Company Address _________________________ City ___________________ State ______ Zip __________

Medical Consent - I hereby consent, for myself or dependant, to diagnostic and/or therapeutic medical treatment, procedures and medical imaging as deemed necessary by the provider. I acknowledge that no guarantee can be made regarding the result of any procedure performed or any medical treatment provided.

Medical Release Authorization - I understand that it may become necessary to release my protected health information to another entity for treatment, follow-up, continuation of care, quality assurance, collection purposes and when required by law. Such entities may include but are not limited to primary care and consulting physicians, specialists, hospitalists, employers, insurance companies and collection agencies.

Certification - I certify that any information I have provided is true and correct to the best of my ability. I further understand that knowingly providing false demographic and/or insurance information constitutes fraud on behalf of the responsible party.

HIPAA - I acknowledge receipt of the Notice of Privacy Rights with detailed information about Lake Oconee Urgent & Specialty Care reserves may use and disclose my protected health information. I understand that Lake Oconee Urgent & Specialty Care reserves the right to change the privacy notice and that a copy of the notice will be made available to me.

____ ______________________

Signature of Patient or Guarantor **Date**

____ ______________________

Signature of Witness **Date**