AUTHORIZATION FOR MEDICAL SERVICES

Date _____

Patient Name _____ Patient Date of Birth _____

Company Name _____ Social Security No. _____

☐ Physical Exam ☐ TB Test ☐ Pre-Employment Drug Screen ◯ with alcohol ◯ without alcohol ☐ Post-Accident Drug Screen ◯ with alcohol ◯ without alcohol

☐ Other Services: _____

TREATMENT FOR INJURY

Injury: _____

Worker's Comp. Insurance Carrier

Street Address

City, State, Zip

Telephone Number Fax Number

Policy Number

EMPLOYMENT SERVICES

Company Name

Street Address

City, State, Zip

Telephone Number Fax Number

Contact

EMPLOYER MUST SUBMIT REPORT OF INJURY (Form 5020) TO WORKER'S COMPENSATION CARRIER WITHIN THREE (3) DAYS OF THE INITIAL INJURY

AUTHORIZATION

On behalf of the above-named company, I hereby authorize Family Care Centers to provide services as indicated above.

Authorized By

Telephone Number

Title/Department

Fax Number

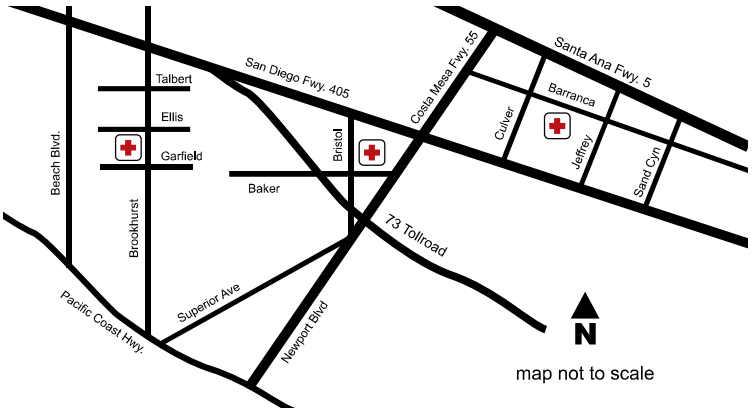
THIS FORM MUST BE PRESENTED TO FAMILY CARE CENTERS AT TIME OF SERVICE

FORM MUST BE SIGNED!

FAMILY CARE CENTERS
MEDICAL GROUP INC

www.fccmg.com

8:00 a.m. to 8:00 p.m. Monday - Friday
8:00 a.m. to 5:00 p.m. Weekends and Holidays



Costa Mesa New Address!
660 Baker Street, Bldg A-102 *(East of Bristol St.)*
Phone (714) 668-2505 Fax (714) 668-2559

Irvine
Woodbridge Medical Building
4950 Barranca Parkway, Suite 104
Phone (949) 857-1248 Fax (949) 559-1165

SKIP THE WAIT!
Check-in online @ www.fccmg.com