Balcatta
Family Practice

Workers Compensation Consent Form

Employee Information

Name:	
Address:	
Telephone:	
Email:	
Type of Injury:	
Date of Injury:	
What/Where Happened:	

Employer Information

Name:	
Address:	
Telephone:	
Email:	

Insurance Company Details

Name:	
Claim Number:	
Contact (if known):	

Patient Consent

I acknowledge that a valid claim number is required for the medical centre to charge the insurance company for the treatment related to my claim. If a claim number is not available, I will settle my account with the medical centre at the end of each consultation and seek reimbursement from the insurance company.

Patient's Signature:_______________________________________ Date: _____ /____ /_____

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