McDonald Chiropractic Clinic
Dr. Gregory McDonald
943 S. Gilbert Street
Iowa City, Iowa 52240
mcdonaldchiropractic.com
(319) 338-2273
(319) 338-1225 fax
mcdonaldchiropractic@gmail.com

WORKERS' COMPENSATION
AUTHORIZATION FOR TREATMENT

Patient: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Employer: _____ Date of Accident: _____

Address: _____ City: _____ State: _____ Zip: _____

TO THE PATIENT: It is necessary that you have your employer sign the following Authorization for Treatment and return it to our office on or before your next visit. If not returned, you will be responsible for payment.

TO THE EMPLOYER: Your signature below acknowledges the work related injury of your above named employee. You are further authorizing our office to render the appropriate care needed for this injury and file the proper forms with your insurance.

BILLING INFORMATION

NAME OF INSURANCE CARRIER: _____

ADDRESS: _____

CITY, STATE, ZIP: _____

AUTHORIZED BY: _____

POSITION: _____ DATE: _____

PLEASE RETURN THIS FORM IMMEDIATELY TO: McDonald Chiropractic
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Iowa City, IA 52240
Phone: 319-338-2273
Fax: 319-338-1225