Acadiana Center for Orthopedic and Occupational Medicine, LLC

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VERIFICATION FOR THE INITIAL VISIT AND/OR TREATMENT

DATE: ___________________________________ **PATIENT:** _______________________________

COMPANY REP.: __________________________ **EMPLOYER:** _____________________________

REPRESENTING: _________________________ **DATE OF INJURY:** ________________________

The above patient has been presented to this office for an appointment on ______________________.

_____ I/We acknowledge financial responsibility for the initial visit that is related to the above dated injury and/or any further treatment that is related to the above injury. I also request and agree to approve any and all narrative reports involving the treatment of this patient. All fees are in accordance with the Louisiana Workers' Compensation Fee Schedule.

SIGNED _________________________ **REPRESENTING** _________________________

*****PLEASE SIGN AND FAX BACK VERIFICATION OF COVERAGE FOR THESE SERVICES*****