

**AUTHORIZATION FOR TREATMENT
WORKERS' COMPENSATION**

Patient: _____ D.O.B: _____ S.S.#: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ Date of Accident: _____
Address: _____ City: _____ State: _____ Zip: _____

TO THE EMPLOYEE: It is necessary that your employer sign this Authorization for Treatment and return it to our office. If not, you will be responsible for payment.

TO THE EMPLOYER: I acknowledge the work related injury of the above named employee. You are authorized to render the appropriate care needed for the injury and we will file the proper forms with our insurance carrier.

Authorized by: _____
Title: _____
Date: _____

PLEASE RETURN THIS FORM IMMEDIATELY TO: Doctor's/Clinic Name: _____
Address: _____
City, State, Zip: _____
Telephone: _____

SPS INC.

231-924-3087

#0210801

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