HOSPITAL STREET DOCTORS

TAC or WorkCover Consent Form

Patient's Name: _____

Address: _____

Phone: _____ Email: _____

Insurance Company: _____

Address: _____

Phone: _____ Fax: _____

Email: _____

Case Manager: _____

Claim Number: _____

Employer: _____

Contact Person: _____

Address: _____

Phone: _____ Fax: _____

****NOTE: if claim is rejected patient will be liable for all outstanding payments.**

Patient Signature: _____ Date: _____