

Occupational Health – Authorization for Services

Date: ____/____/____

PATIENT/EMPLOYER INFORMATION

_____ /____/____ _____ - ____ - ____
 Patient Last Name Patient First Name Date of Birth Social Security #

_____ _____
 Employer Name Employer Contact Name

(____) _____ - _____ (____) _____ - _____ _____
 Employer Contact Phone Employer Contact Fax Employer Contact Email

VISIT INFORMATION

Payment Method:	<input type="checkbox"/> Bill the Employer <input type="checkbox"/> Patient Will Pay <input type="checkbox"/> Submit to Workers Comp Insurance
Drug Screen:	<input type="checkbox"/> Rapid 5-Panel <input type="checkbox"/> Rapid 10-Panel <input type="checkbox"/> DOT <input type="checkbox"/> Non-DOT <input type="checkbox"/> Collection Only Other: _____ <input type="checkbox"/> Pre-Employment <input type="checkbox"/> Post-Accident <input type="checkbox"/> Return to Work <input type="checkbox"/> For Cause <input type="checkbox"/> Random
Physical:	<input type="checkbox"/> General Work <input type="checkbox"/> DOT <input type="checkbox"/> Other: _____
Screenings:	<input type="checkbox"/> TB PPD <input type="checkbox"/> EKG <input type="checkbox"/> BAT <input type="checkbox"/> Rapid UA <input type="checkbox"/> Eye Exam <input type="checkbox"/> Pulmonary Function Other: _____
Vaccines:	<input type="checkbox"/> Flu <input type="checkbox"/> Hep A <input type="checkbox"/> Hep B <input type="checkbox"/> MMR <input type="checkbox"/> Pneumococcal <input type="checkbox"/> Tetanus <input type="checkbox"/> Varicella Other: _____
Lab Tests:	<input type="checkbox"/> CBC <input type="checkbox"/> Hep A/B/C Titer <input type="checkbox"/> MMR Titer <input type="checkbox"/> Varicella Titer <input type="checkbox"/> Lead Assay Other: _____
Workers Comp:	<input type="checkbox"/> Initial <input type="checkbox"/> Follow-up WC Carrier: _____ Injury Date/Time: _____ Claim ID: _____ Insurance Adjustor: _____

ADDITIONAL INFORMATION / INJURY DESCRIPTION

AUTHORIZATION

By signing this agreement, the above stated company is responsible for charges accrued. Net payment is due 30 days from date of invoice.

 Print Name and Title of Employer Authorized Representative

_____ _____ / ____ / ____
 Employer Authorized Representative Signature Date