

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	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"/> T-DAP <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