Occupational Health – Authorization for Services

Date: _____/_____/_____

HEALTH FIRST

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:	☐ Bill the Employer ☐ Patient Will Pay ☐ Submit to Workers Comp Insurance
Drug Screen:	☐ Rapid 5-Panel ☐ Rapid 10-Panel ☐ DOT ☐ Non-DOT ☐ Collection Only Other: _____ ☐ Pre-Employment ☐ Post-Accident ☐ Return to Work ☐ For Cause ☐ Random
Physical:	☐ General Work ☐ DOT ☐ Other: _____
Screenings:	☐ TB PPD ☐ EKG ☐ BAT ☐ Rapid UA ☐ Eye Exam ☐ Pulmonary Function Other: _____
Vaccines:	☐ Flu ☐ Hep A ☐ Hep B ☐ MMR ☐ Pneumococcal ☐ Tetanus ☐ Varicella Other: _____
Lab Tests:	☐ CBC ☐ Hep A/B/C Titer ☐ MMR Titer ☐ Varicella Titer ☐ Lead Assay Other:
Workers Comp:	☐ Initial ☐ 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

Revised: 04/01/2019