

**Authorization for Treatment**

**Patient Name: Appt Time: Date:**

**Company: Phone: Fax:**

**Company Address: City: State: Zip:**

**Supervisor: Email: FAX:**

**Authorized By: Date:**

**By signing this authorization the above referenced company acknowledges and agrees that it is fiscally responsible for all incurred charges at this facility.**

**Verbal Authorization Given by: Taken By: h Name Phone# Initials**

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| --- | --- |
| **Work-Related Injury/Illness** | **\_\_ Evaluate \_\_Treatment** **Body Part: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position in Company\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\*Send incident report, if available*****If this incident is deemed not work-related, the authorizing organization will be responsible for charges until notification is given*** |
| **Drug Screen**  | **\_\_DOT \_\_NON-DOT (\_\_Urine Lab \_\_Urine Rapid \_\_Hair \_\_Saliva)****\_\_Post Offer \_\_Post Accident \_\_Reasonable Suspicion \_\_Random \_\_Follow Up \_\_Witnessed/Observed \_\_Employee to Pay** |
| **Breath Alcohol** | **\_\_DOT \_\_NON-DOT** **\_\_Post Offer \_\_Post Accident \_\_Reasonable Suspicion \_\_Random \_\_Follow Up \_\_Witnessed/Observed \_\_Employee to Pay** |
| **Physical Exam** | **\_\_ Post Offer \_\_DOT \_\_Annual \_\_Respiratory Clearance \_\_Toxic \_\_Asbestos** **\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_Employee to Pay** |
| **Immunization** | **\_\_ TB \_\_Tetanus \_\_MMR \_\_Hep A \_\_HepB \_\_Flu****\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_Employee to Pay** |
| **Other** | **\_\_PFT \_\_Audiometry \_\_EKG \_\_Spirometry \_\_Respirator Fit Test****\_\_Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****\_\_Employee to Pay** |

**Special Instructions:**

**(All patient must bring valid PHOTO ID to the appointment. Patients under 18 years of age need written parental authorization for physicals, injury treatment and/or injections.**