Treatment Authorization Form

Employee must present authorization form and government issued Photo ID at time of service.
If written or verbal authorization is not provided by an authorized representative from the patient's employer, the patient (employee) assumes financial responsibility prior to services being rendered.

Work-Related Accident Services

Occupational Health Services Only: continue to page 2

Patient Information

First & Last Name:	Date of Birth (MM/DD/YY): Social Security Number:

Employer Information

Company Name:	Authorizing Employer Representative & Title:	
Company Phone Number:	Direct Phone Number:	Fax Number:

Work-Related Injury

Claim Number:	Date of Injury:
Body Part(s) Authorized to Evaluate/Treat:	

Is a post-accident drug screen and/or breath alcohol test required? (Check all that apply):

☐ **No Post-Accident Testing Required** ☐ Urine Collection with COC ☐ Breath Alcohol Test (BAT)
☐ 5 Panel DOT eScreen ☐ 5 Panel eScreen ☐ 10 Panel eScreen

Reason for Drug & Alcohol Test: ☑ **Post-Accident** **Authorized By:** ☐ **Employer** ☐ **Insurance Carrier**

Workers' Compensation Insurance Carrier

Insurance Carrier Name:	Assigned Adjuster Name:	
Insurance Carrier Phone Number:	Direct Phone Number:	Fax Number:

EMPLOYER AUTHORIZATION: I authorize MD Now Medical Centers, Inc. to provide work related accident services and understand that my company (listed above) will be financially responsible for all services rendered to the patient (listed above). I further understand that it is my company's responsibility to provide a claim number for all work-related injuries to MD Now Medical Centers, Inc. within 7 days of this authorization.

Employer Representative (Print Name)	Employer Representative Signature	Date

☐ **CLINIC USE ONLY:** VERBAL AUTHORIZATION RECEIVED BY THE ABOVE LISTED EMPLOYER REPRESENTATIVE

MD Now Employee (Print Name)	MD Now Employee Initials	YES NO Corporate Account	Date

Treatment Authorization Form

MD NOW URGENT CARE

Employee must present authorization form and government issued Photo ID at time of service.
If written or verbal authorization is not provided by an authorized representative from the patient's employer, the patient (employee) assumes financial responsibility prior to services being rendered.

Occupational Health Services

Work-Related Accident Services: return to page 1

Patient Information

First & Last Name:	Date of Birth (MM/DD/YY): Social Security Number:

Employer Information

Company Name:	Authorizing Employer Representative & Title:	
Company Phone Number:	Direct Phone Number:	Fax Number:

Physicals (Check All That Apply – Exam & Vital Signs Required)

☐ General Work Physical	☐ DOT Physical	☐ Fire/Police Physical	☐ Respiratory Mask Physical
Exam & Vital Signs	Exam & Vital Signs Medical Examiners Cert	Exam & Vital Signs FDLE 75 / 75a Form	Exam & Vital Signs OSHA Questionnaire Form Respiratory Mask Fit Test

Check any additional service required (included with any Physical): ☐ Urinalysis ☐ Vision Acuity (Snellen) ☐ Whisper Hearing

Labs (Physical Exam Required)

☐ Comprehensive Metabolic Panel (CMP)		☐ CBC w/Diff and Platelet	☐ Lipid Panel
☐ Hepatitis A Antibody, Total (Immunity)	☐ Hepatitis B Surface Antibody, QN (Titer)	☐ Hepatitis B Core IgM Antibody Total w/Reflex	☐ Hepatitis B Surface Antigen
☐ Hepatitis C Antibody (Screen)	☐ Measles Antibody IgG (Rubeola Titer)	☐ Mumps Virus Antibody IgG (Titer)	☐ Rubella Immune Status IgG (Titer)
☐ Varicella Zoster Virus IgG (Titer)	☐ Bordetella Pertussis Antibodies (IgG)	☐ QuantiFERON-TB Gold (In-Tube Test QQFT-GIT)	☐ HIV-1/2 (4th Gen) Antigen/Antibody

Vaccines (Physical Exam Required except for Seasonal)

☐ Hepatitis B (20 years & up)	☐ MMR	☐ Tdap	☐ Tetanus Diphtheria	☐ Influenza SEASONAL

Additional Services (Physical Exam Required)

☐ PPD (1 STEP) ☐ PPD (2 STEP)	☐ Color Vision (Ishihara)	☐ Audiometry	☐ Spirometry	☐ EKG	☐ Chest X-Ray (1 View)

Drug & Alcohol Screenings (Check All That Apply – Chain of Custody, ePassport or Treatment Auth Required)

☐ 5 Panel DOT eScreen ☐ 5 Panel eScreen ☐ 10 Panel eScreen
☐ Urine Collection with COC ☐ Breath Alcohol Test (BAT)

Reason for Drug & Alcohol Test: ☐ Pre-Employment ☐ Random ☐ Reasonable Suspicion ☐ Return to Duty ☐ Follow-Up

EMPLOYER AUTHORIZATION: I authorize MD Now Medical Centers, Inc. to provide occupational health services and understand that my company (listed above) will be financially responsible for all services rendered to the patient (listed above).

Employer Representative (Print Name)	Employer Representative Signature	Date

☐ **CLINIC USE ONLY:** VERBAL AUTHORIZATION RECEIVED BY THE ABOVE LISTED EMPLOYER REPRESENTATIVE

MD Now Employee (Print Name)	MD Now Employee Initials	YES NO Corporate Account	Date