Maine Urgent Care

Employer Authorization Form

Complete this form (all fields) and present at time of service

Date: _____ Patient Name: _____

Employer: _____ Phone: _____ Fax: _____

Employer Address: _____

Primary Contact: _____ Email: _____

Employee Education - health & wellness

- ____ ☐ Hearing Screening
- ____ ☐ Hearing Screening
- ____ ☐ Vision Screening
- ____ ☐ Vision - injury diagnosic
- ____ ☐ Physicals - DOT/DMV
- ____ ☐ Physicals - Pre-employment/post-offer
- ____ ☐ Physicals - Pre-employment/post-offer
- ____ ☐ Physicals - Return to work - injury
- ____ ☐ Physicals - Return to work - sickness
- ____ ☐ Physicals - Customize based on employer
- ____ ☐ Respirator Fit Testing - half face
- ____ ☐ Respirator Fit Testing - full face
- ____ ☐ Respirator Fit Testing - N95
- ____ ☐ Pulmonary Function Test (Spirometry)
- ____ ☐ Pulmonary Function Test (Other)

Drug/Alcohol Testing

- ____ ☐ 10 Panel Drug Test
- ____ ☐ 5 Panel Drug Test
- ____ ☐ Alcohol Saliva Test (PWC)
- ____ ☐ Breath Alcohol Testing
- ____ ☐ Urine Drug Screening (regulated)
- ____ ☐ MRO Services

Radiology Studies

- ____ ☐ Chest X-ray (1-2 views)
- ____ ☐ X-ray of Upper Extremities (3-5 views)
- ____ ☐ X-ray of Lower Extremities (3-5 views)

Vaccines

- ____ ☐ Immunizations - Hep A
- ____ ☐ Immunizations - Hep B
- ____ ☐ Immunizations - Influenza
- ____ ☐ Onsite Flu vaccinations
- ____ ☐ Immunizations - MMR
- ____ ☐ Immunizations - Rabies
- ____ ☐ Immunizations - TD
- ____ ☐ Immunizations - tDAP

Physical Therapy

- ____ ☐ Physical Abilities Testing (PAT) - Grip
- ____ ☐ PAT - Functional Capacity Evaluation
- ____ ☐ PAT - Lift testing
- ____ ☐ Work Rehabilitation Programs

In-house Lab (Send-outs in "ES Lab" Section)

- ____ ☐ Flu Nasal Swab - A and B
- ____ ☐ Glucose
- ____ ☐ Hematocrit
- ____ ☐ Hemoglobin
- ____ ☐ Pregnancy Test - Urin HCG IRL
- ____ ☐ Urinalysis - dip
- ____ ☐ Urinalysis (Micro) Complete
- ____ ☐ TB Screening, Blood
- ____ ☐ TB Screening, Skin

Reference Lab Send-outs

- ____ ☐ Arsenic Fractionation Test (Further Testing If Medically Indicated)
- ____ ☐ Blood Alcohol Test
- ____ ☐ Heavy Metal (Spot Urine - Arsenic/Lead/Merc/Cadmium)
- ____ ☐ Heavy Metal Profile (24 Hr Collection - 7 Metals)
- ____ ☐ Hepatitis A Surface Antibody
- ____ ☐ Hepatitis B Antigen
- ____ ☐ Hepatitis B Core Antibody
- ____ ☐ Hepatitis B Surface Antibody
- ____ ☐ Hepatitis C Antibody Test
- ____ ☐ Hiv 1 Test
- ____ ☐ Hiv 2 Test
- ____ ☐ Lyme Disease Confirmation - Automatic If Eval
- ____ ☐ Lyme Disease Serology Eval
- ____ ☐ Malaria Blood Smear Test
- ____ ☐ Measles Titer
- ____ ☐ Mercury Urine
- ____ ☐ Methemoglobin Level
- ____ ☐ Mumps Titer
- ____ ☐ Phenol, Urine
- ____ ☐ Quantiferon Test
- ____ ☐ Rabies Antibody
- ____ ☐ Rubella Titer
- ____ ☐ Rubeola Titer
- ____ ☐ Toxoplasma Igg Antibody
- ____ ☐ Toxoplasma Igm And Igg Antibody
- ____ ☐ Uds-Medpro Panel (Healthcare Workers)
- ____ ☐ Uric Acid
- ____ ☐ Varicella Titer
- ____ ☐ Urine Collection
- ____ ☐ Blood Clollection
- ____ ☐ EKG

Administration

- ____ ☐ On site Nurse per hour $37.00
- ____ ☐ OSHA Respiratory Fit Test and Review: *-this charge is in addition to the mask charge of **$27.00***

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WELLNESS SERVICES

- ____ ☐ Biometric Screening

ONSITE TRAINING SERVICES

- ____ ☐ Heart Healthy
- ____ ☐ Nutrition
- ____ ☐ Stress Relief
- ____ ☐ Diabetes
- ____ ☐ Tobacco Cessation
- ____ ☐ Weight Control
- ____ ☐ Back Care
- ____ ☐ Sleep Disorders
- ____ ☐ Men and Women's Health
- ____ ☐ Bloodborne OSHA Training Services

REQUIRED FOR ALL WORKERS' COMPENSATION VISITS

☐ Workers' Compensation Injury Treatment Date of Injury: _____ Type of Injury: _____

☐ Post Accident Drug Screen Required ➡ *Check Type Above* Has employer filled out First Report of Injury? ☐ Yes (send copy) ☐ No

☐ Post Accident DOT Drug Screen Required ➡ *Check Type Above* Breath Alcohol Testing ☐ DOT (82075.D) or ☐ Non-DOT (82075.N)

Where are claims to be filed? ☐ Bill Employer ☐ Insurance Carrier W/C Carrier Name: _____

W/C Carrier Address: _____

W/C Carrier Phone: _____ W/C Carrier Fax: _____ Policy Number: _____

BILLING INSTRUCTIONS

☐ Bill Patient - Payment due at time of service

☐ Bill Credit Card

☐ Bill Established Employer Account *(account must be current - no past due balance)*

Name on Card: _____ Card Number: _____ Exp Date: _____ Code: _____

Card Address: _____ City: _____ State: _____ Zip Code: _____

Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

EMPLOYER This certifies that the above information is correct. I authorize the medical provider to provide medical treatment to the employee named above. I also understand that the services provided will be paid in full by the company listed above and authorized by my signature below.

X _____ _____ _____ Title: _____

Employer Signature (REQUIRED) Date **Printed Name (REQUIRED)**

EMPLOYEE SIGNATURE & STATEMENT

I understand that I will be responsible for payment of services indicated above should circumstances arise resulting in non-payment from my employer.

X _____ _____

Employee Signature (REQUIRED) Date

Maine Urgent Care Team Member: _____ LOCATION: _____

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