Treatment Authorization Form

MD NOW URGENT CARE
Affiliated with HCA Florida Healthcare

Account Code: _____

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 Injury Services

Employer Paid 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 Address:	Direct Phone Number: _____ Email Address: _____	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**
eScreen Acct #: _____

Workers' Compensation Insurance Carrier

Insurance Carrier Name:	Assigned Adjuster Name:	
Insurance Carrier Phone Number:	Direct Phone Number: _____ Email Address: _____	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

For clinic hours and to find a location, go to www.MDNow.com

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

MD Now Employee (Print Name)	MD Now Employee Initials	MD Now Location	Date

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Employer Paid Services

Work-Related Injury 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 Address:	Direct Phone Number: _____ Email Address: _____	Fax Number:

Physicals

☐ **General Work Physical**
Exam & Vital Signs

☐ **DOT Physical**
Exam & Vital Signs
Medical Examiners Cert

☐ **Fire/Police Physical**
Exam & Vital Signs
FDLE 75 / 75a Form

☐ **Respiratory Mask Physical**
Exam & Vital Signs
OSHA Questionnaire Form
Respiratory Mask Fit Test

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

Labs

☐ Hepatitis A Antibody (Immunity)	☐ **M**easles Titer (Rubeola)	☐ CMP Comprehensive Metabolic Panel
☐ Hepatitis B Surface (Titer)	☐ **M**umps Titer	☐ CBC w/Diff and Platelet
☐ Hepatitis B Core IgM Antibody	☐ **R**ubella Titer	☐ Lipid Panel
☐ Hepatitis B Surface Antigen	☐ Varicella Zoster Titer	☐ HIV
☐ Hepatitis C Antibody (Screen)	☐ Bordetella Pertussis	☐ QuantiFERON-TB Gold

Vaccines

☐ Hepatitis B	☐ Tetanus Diphtheria	☐ Influenza
☐ MMR	☐ Tdap	

Additional Services

☐ PPD (1 STEP)	☐ Chest X-Ray (1 View)	☐ Audiometry
☐ PPD (2 STEP)	☐ Lumbar X-Ray (2 View)	☐ Spirometry
☐ EKG	☐ Color Vision (Ishihara)	☐ Other: _____
☐ OSHA / Medical Questionnaire	☐ Mask Fit Test	

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)	■ **eScreen Account #:** _____

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 employer paid 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

For clinic hours and to find a location, go to www.MDNow.com

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

MD Now Employee (Print Name)	MD Now Employee Initials	MD Now Location	Date