EMPLOYER'S AUTHORIZATION FOR EXAMINATION OR TREATMENT

(MUST PRESENT PHOTO ID AT TIME OF SERVICE)

Date: ________________________________

Patient Name: ________________________________ Date of Birth: ________________________________

Company Name: ________________________________ Date of Injury: ________________________________

Address / Location#: ____

WORK-RELATED ___INJURY / ___ILLNESS

***Post-Accident** Substance Abuse Testing:*

_______ Drug Screen: [ ] Urine [ ] Hair
[ ] 5 Panel [ ] 10 Panel

_______ Breath Alcohol

_______ Urine Collection Only (Employer to provide COC)

TEST TYPE

_______ DOT Regulated

_______ Non-Regulated

BILLING

_______ Bill Company for services (excludes Work Comp, unless the Company has a "Direct Bill Agreement "signed and on file with DocNow)

_______ Employee to pay at time of service

_______ Bill Workers' Compensation Carrier

Carrier: ________________________________

Claim#: ________________________________

Phone #: ________________________________

Address: ________________________________

PHYSICAL EXAMINATIONS

_______ DOT Physical [ ] Pre-employment
[ ] Recertification

_______ Pre-employment

_______ Return to work Physical

_______ Other:________________________________

DRUG & ALCOHOL TESTING

Reason for Test:

[ ] Pre-Employment [ ]Random [ ] Post-Accident

[ ] Reasonable Suspicion [ ] Other: ____________________

_______ DOT Urine

_______ Non DOT Urine [ ] 5 Panel [ ] 10 Panel

_______ Urine Collection Only (Employer to provide COC)

_______ Breath Alcohol

_______ Hair Drug Test

_______ Hair Collection Only (Employer to provide COC)

OTHER:

_______ TB Test

_______ Other: ____________________

EMPLOYER AUTHORIZATION (Authorization for services is valid for 24 hours from the date and time it was signed)

Authorized By: ________________________________ Title: ________________________________

Phone #: ________________________________ Date / Time: ________________________________

FOR DOCNOW USE ONLY [ ] Yes Obtained consent for treatment

Signature: ________________________________ Date / Time: ________________________________

4764 Dixie Highway, Waterford, MI 48329 | Ph: (248) 461-8600 Fax: (248) 461-8700
1701 South Blvd. East, Suite 150, Rochester Hills, MI 48307 | Ph: (248) 853-6300 Fax: (248) 853-6303
1-888-8-DocNow | www.8docnow.com