Authorization for Medical Business Health Services

Pardee Urgent Care	Pardee Urgent Care	Pardee Urgent Care	Pardee Urgent Care
45 Hendersonville Hwy	212-A Thompson St	2695 Hendersonville Rd	3334 Bolyston Hwy Suite 10
Pisgah Forest NC 28768	Hendersonville NC 28792	Arden NC 28704	Mills River NC 28759
Phone: (828) 435-8100	Phone: (828) 697-3232	Phone: (828) 694-2350	Phone: (828) 694-8100
Fax: (828) 435-8101	Fax: (828) 698-9570	Fax: (828) 694-2351	Fax: (828) 694-8101

Todays Date:___________________________ *ICD-10 Code:*

Reason for Visit: ☐ Pre-Employment ☐ Employment ☐ School/Sports/Camp ☐ Random ☐ Post Accident ☐ For Cause

☐ **DOT Driver's License:** Do you have any known medical issues that must be addressed for completion of Forms? ☐ Yes ☐ No

☐ **Work Related Injury:** Complaint/Injury: ____ Date of Injury : _______________

Drug Screen : ☐ DOT ☐ Non-DOT Observed: Yes / No ☐ No Drug Screen Required *Test Done:*

Services Requested (Check all that apply): ☐ Physical ☐ Breath Alcohol Test ☐ Pulmonary Function Test ☐ Breathing Capacity

☐ Respirator Fit Test ☐ Audiometry ☐ Vision ☐ Lift Test/Range of Motion ☐ Strength/Flexibility ☐ TB Skin Test

Vaccine (Type) : ____

Labs (Check all that apply): ☐ Urinalysis ☐ Rubeola ☐ Mumps ☐ Rubella ☐ Varicella ☐ Hep B ☐ Hep C ☐ HIV ☐ T-Spot

Radiology: ☐ Chest X-ray (1 View) ☐ Chest X-ray (2 Views)

Other:____

EMPLOYER Information (Please complete information using the mailing address as the "Bill To" address)

Type of Employee: ☐ **Permanent** ☐ **Contract** ☐ **Temporary**

Company Name:____ **Work Comp Insurance:**________________________________

Mailing Address: ____ **Address:** ____________________________________

City,State, Zip: ____ **City,State, Zip:** ______________________________

Phone: (_______) ____ **Phone: (_______)** ______________________________

Contact Name and Email:___________________________________

Service Requested/Authorized by: ____

Bill Claim To: ☐ **Company Address as Above** ☐ **Work Comp Insurance Carrier** ☐ **Self-Pay,Prepayment**

***** Please Note*** The patient will be asked to provide a copy of their personal health insurance cards and information. This will be used in case of denial by the employer or the employer's work comp insurance carrier, as it relates to this service and/or any other services related to this visit. However, the patient will be responsible for any co-pays, deductibles, unpaid or denied charges related to this claim.**

EMPLOYEE - Patient Information Please Print Clearly

Full Name: ____

Medical Insurance: _______________________________________ **Soc Sec Number:** ______________________________

Mailing Address: ____ **Sex: Male Female**

City,State,Zip: ____ **Date of Birth:** ________________________________

Phone: Home (_________)_________________________ **Cell (__________)**____________________________

Do you have a Primary Care Provider [ ] Yes [ ] No Name:____ **Location:** _____________________

Patient/Guardian Signature____ **Date:** ______________________

***Note:** 1) All entries must be completed before the patient can be seen. 2) A new authorization form must be completed for each new injury or service. DO NOT complete for Work Comp claims previously authorized. Thank you!*