fastpace health

eScreen Account:
Account Type: Clinic Client

Employer Authorization Form

Patient must present Photo ID and Authorization Form at time of service

SECTION I:	**PATIENT INFORMATION**		
First Name		Last Name	
Date of Birth (MM/DD/YYYY)		SSN	
SECTION II:	**COMPANY INFORMATION**		
Employer Name			
Fast Pace Account #			
Primary Contact		Phone Number	
Address City, State, ZIP		Email	

SECTION III: AUTHORIZED SERVICES (check all that apply for this visit)

Reason for Testing: ☐ Pre-Employment ☐ Reasonable Suspicion ☐ Random ☐ Post-Accident ☐ DOT Return to Work (Observed Required) * ☐ Other:

DRUG SCREENING:

☐ Urine Collection Only* (80306UC)
*only if Employer supplies their own Chain-of-Custody Form.
☐ Federal DOT (80306)
☐ Breath Alcohol Test (82075)
☐ Observed Fee (99211OF)
☐ eCup+11E Instant (80306)
☐ 10 Panel Lab (80306)
☐ TN Drug Free (80306)

PHYSICAL EXAM:

☐ NonDOT Physical (99455ND)
☐ DOT Physical (99455)
☐ Fit For Duty (97161)
☐ Lift test (97161L)
☐ **OTHER:**

IMMUNIZATIONS:

☐ Tetanus, (Tdap) (90715)
☐ Tetanus, Diphtheria (90714)
☐ **OTHER:**

LABS:

☐ Hepatitis A Titer (86708)
☐ Hepatitis Panel 4 (80074)
☐ Varicella Titer (86787)
☐ Hepatitis B Titer (86317)
☐ PPD/TB Gold (86480)
☐ PPD Questionnaire (86580Q)
☐ Hepatitis C Titer (86803)
☐ MMR Titer (86735, 86765, 86762)
☐ **OTHER:**

OTHER TESTING:

☐ EKG (93000
☐ Visual Acuity Test – Snellen (99173)
☐ Audiogram (92552)
☐ Pure Tone Audiometry (92551)
☐ Chest X-ray 1 or 2 view (71046)
☐ Color Vision Exam (92283BCS)
☐ **OTHER:**

SECTION IV: WORKERS' COMPENSATION

☐ Workers' Compensation Injury Treatment ☐ Workers Comp Initial Visit Only

Date of Injury:_____ Type of Injury/Body Part: _____

W/C Authorization Number: _____

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:_____

SECTION V: CUSTOMER ACKNOWLEDGEMENT

EMPLOYER: I hereby authorize the medical provider to treat the named employee above. I acknowledge that all services will be paid for in full by the listed company. Unless stated otherwise in Section IV, this authorization covers both the initial and necessary all follow-up visits. By signing below, I certify the correctness of all information and consent to the stipulated terms.

X_____ _____ _____ _____

Employer Authorized Signature (Required) **Date** **Employer Printed Name (Required)** **Title**