

Visit ID _____



Work Comp Intake Form

A copy of this form must accompany employee to test site or be sent to test site.

Employee Last Name:		Employee Middle Initial:	Employee First Name:
Employee Date of Birth:	Employee SSN:	Employee Email Address:	
Employee Mailing Address:			Employee Phone Number:
Chief Complaint:		Date of Injury:	Claim Number:
Have you been treated previously for your injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, when and where was your last date of treatment?	

--Services to be provided? Please select what services need to be performed for TODAY's visit--

Evaluation	Drug Screens	Breath Alcohol Tests
<input type="checkbox"/> Provider evaluation of work comp injury/work-related injury	<input type="checkbox"/> 5 panel DOT drug screen – [OMDOTDRUG] Mode of transportation: _____ Reason for testing: _____ <input type="checkbox"/> 5 panel NON-DOT drug screen – [OM5PANEL] <input type="checkbox"/> 10 panel drug screen – [OM10PANEL] <input type="checkbox"/> 7 panel drug screen + alcohol – [OMURINEDRUG+ALCOHOL] <input type="checkbox"/> synthetic marijuana/bath salts drug screen – [OMSYNTHETICMARIJUANA] <input type="checkbox"/> 14 panel send out drug screen – [OM14PANEL] <input type="checkbox"/> 14 panel rapid drug screen – [OMG0434] <input type="checkbox"/> Confirmation of rapid non-negative drug screen – [OMRAPIDCONFIRMATION] <input type="checkbox"/> Collection only drug screen – [OMCOLLECTONLY] Lab: _____ Panel/Type of test: _____ <input type="checkbox"/> Direct observation of urine collection – [OMDIRECTOBSERVE]	<input type="checkbox"/> DOT breath alcohol test (BAT) – [OMDOTBAT] <input type="checkbox"/> NON-DOT breath alcohol test (BAT) – [OMBAT]

Employer Representative Name: _____			
Employer Representative Signature: X _____			
Contact for Results Name:	Contact for Results Phone Number:	Contact for Results Fax:	Contact for Results Email:

Company/Employer Name:		Company/Employer Billing Address:	
Billing Contact Name:	Billing Phone Number:	Billing Fax Number:	Billing Email:
Work Comp Carrier Name:		Work Comp Carrier Billing Address:	
Claims Adjuster Name:	Claims Adjuster Phone Number:	Claims Adjuster Fax:	Claims Adjuster Email:

Privacy, Billing, and Other Important Information

I authorize Rural Urgent Care LLC/MainStreet Family Urgent Care to contact me at the number listed above and leave a voicemail if I am unavailable. I have read and reviewed Rural Urgent Care LLC/MainStreet Family Urgent Care's Billing Policies and Privacy Policy. We will file a claim with your employer's insurance company for the services provided. In the event of non-payment you will be responsible the charges incurred today. I authorize release of any information concerning my health care and treatment for the purpose of evaluating and administering claims of insurance benefit. Furthermore, I authorize release of any information pertaining to today's visit to my employer. I consent to care and treatment of myself by the attending provider and his/her associates and assistants.

X _____ Date: _____
 (Signature of patient)