I & O MEDICAL CENTER ACCOUNT SET UP INFORMATION

Company Name: _____ Point of Contact: _____

Address: _____ Point of Contact: _____

_____ Accounts Payable: _____

Billing Address: _____ Work Comp POC: _____

_____

Phone: _____ Fax: _____ Phone: _____ Fax: _____

Email: _____ Email: _____

After Hours Contact: _____ Phone: _____ Phone: _____

SERVICES REQUESTED:

Pre-Employment Physicals ☐	Audiometry ☐	Vaccine ☐ Type: _____
Annual Physicals ☐	Spirometry ☐	Vaccine ☐ Type: _____
DOT Physicals ☐	EKG ☐	Vaccine ☐ Type: _____
Ergo Physicals ☐	Respirator Fit ☐	Blood Draw ☐ Type: _____
Hazmat Physicals ☐	TB Screening ☐	Blood Draw ☐ Type: _____
Respirator Physicals ☐	Vision Screening ☐	Blood Draw ☐ Type: _____

Other ☐ _____ Other ☐ _____

Other ☐ _____ Other ☐ _____

10 Panel Urine Drug Screen (our forms) ☐	5 Panel Urine Drug Screen (our forms) ☐
10 Panel Urine Quick Test (non DOT only) ☐	5 Panel Urine Quick Test (non DOT only) ☐
Hair Drug Screen (our forms) ☐	Breath Alcohol Test (our forms) ☐ OR Special Forms ☐

Urine Drug Screen- ***collection only*** ☐: Employee to bring in forms/kit ☐ OR Forms kept on file at I & O ☐

Hair Drug Screen- ***collection only*** ☐: Employees to bring in forms/kit ☐ OR Forms kept on file at I & O ☐

Contact to order more forms (if kept on file): _____ Phone: _____

Physical Results/ Paper work: Give originals to employee ☐ Mail originals ☐ Fax results ☐

DOT Card/ Physical Results: Give both to employee ☐ Give only DOT card to employee ☐ Mail originals ☐

Drug Screen Results: Quick Test: Mail ☐ Fax ☐ Give to employee ☐

All other results: Mail ☐ Fax ☐

Contact: _____ Secure Fax Line: _____

Mailing address: _____

Additional Instructions:

_____

I & O Medical Centers Protocols:

Respirator clearance protocol ☐ Respirator Fit protocol ☐ PPD protocol ☐

Hazmat protocol ☐ DOT Physicals with glucose/hemoglobin testing ☐ EMR forms ☐

By signing below I assure that all information provided is correct and that all protocols will be carried out for each employee sent to I & O for any services or treatment. Should any protocols need to be updated I will contact the client services representative to make the corrections.

Name: _____ Date: _____

Signature: _____

WORKERS COMPENSATION INFORMATION

Insurance Carrier Name: _____

Address: _____

_____

Phone: _____ Fax: _____

Case Worker: _____ Phone: _____ ext.: _____

☐ I understand that a first report of injury must be reported to the insurance carrier by my company for every new workers compensation claim.

☐ I decline to provide the Workers Compensation insurance carrier information and would like the bill to be sent to our company directly.

*Please note if you do not provide workers compensation insurance that you are responsible for payment on all workman's compensation claims. We will direct all billing for these claims to your company and you will be responsible to either pay for the claims directly or forward the bills and medical documentation to your insurance carrier yourself. In this case you will be responsible for all correspondence with your insurance carrier regarding payments, information needed, etc.

Testing:

☐ A urine drug screen is required for every workers compensation claim

☐ A breath alcohol test is required for every workers compensation claim

☐ A urine drug screen or breath alcohol test will be performed by request only

Medical Documentation:

☐ I would like all medical documentation, work notes, etc. faxed secure fax line: _____

☐ I would like all medical documentation, work notes, etc. emailed secure email: _____

* All emails will be sent through a secure zipped email and require you to enter a password

* Your password will be: _____ (6 characters max)

☐ I would like all medical documentation, work notes, etc. mailed Address: _____

_____