

Urgent Care & Occupational Medicine Clinic Client Protocol Service Agreement

Business Name: _____ Phone: _____ Fax: _____
Contact: _____ Title: _____
Mailing Address: _____ City, State, Zip: _____

Contact for Treatment of Work Related Injuries

Name: _____ Title: _____ Phone: _____
Fax: _____
Secured: yes _____ no _____

Name: _____ Title: _____ Phone: _____
Fax: _____
Secured: yes _____ no _____

Do you require a post-accident drug test or breath alcohol test? yes _____ no _____

Insurance Information

(please fill out completely)

Work Comp Insurance Carrier: _____ Policy Number: _____

Contact: _____ Phone: _____

Carrier Address: _____ City, State, Zip: _____

Group Health Carrier: _____ Policy Number: _____

Contact: _____ Phone: _____

Carrier Address: _____ City, State, Zip: _____

Billing Information

(if different than insurance information)

Company: _____ Contact: _____ Phone: _____

Address: _____ City, State, Zip: _____

(please see reverse side)

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COLORADO SPRINGS HEALTH PARTNERS, P.C.

Services and Requirements

	DOT	Post Offer	Physical Abilities	Hazmat Initial	Hazmat Periodic	Respiratory Initial	Respiratory Periodic
Physical							

Drug Testing

NIDA		
NonNIDA		
Collection Only		
BAT		

Post-Accident Work-Related

Drug Testing

	NIDA	NonNIDA	BAT
Post Accident			
Random			
On Request Only			
For Cause			

Other Services

	YES	NO
Hepatitis B Vacc.		
TB Test		

Lab Preference: _____

Hospital: _____

PT/Rehab: _____

Case Management: _____

Comments: _____

Name of person

Completing this form: _____ Title: _____ Date: __/__/__