Urgent Care & Occupational Medicine Clinic
Client Protocol Service Agreement

Business Name:_____ Phone: _____ Fax: _____
Contact: _____ Title: _____
MailingAddress:_____ 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: _____

_____ _____
Signature Date

(please see reverse side)

www.cshp.net

CSHP
COLORADO SPRINGS HEALTH PARTNERS
A DaVita Medical Group

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
Hepititis B Vacc.		
TB Test		

Lab Preference: _____

Hospital: _____

PT/Rehab: _____

Case Management: _____

Comments: _____

_____

Name of person
Completing this form: _____

Title:_____ Date: ____/____/_____