Visit ID _____

Work Comp Intake Form

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

MainStreet FAMILY CARE
Occupational Medicine & Workers Compensation

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? ☐ Yes ☐ 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**
☐ Provider evaluation of work comp injury/work-related injury	☐ 5 panel DOT drug screen – [OMDOTDRUG] Mode of transportation: _____ Reason for testing: _____ ☐ 5 panel NON-DOT drug screen – [OM5PANEL] ☐ 10 panel drug screen – [OM10PANEL] ☐ 5 panel rapid drug screen (DOES NOT INCLUDE THC) -[OMNONTHCRAPID] ☐ 12 panel rapid drug screen – [OMG0434] ☐ 12 panel confirmation of rapid Non-Negative drug screen (INCLUDES THC) – [OMRAPIDCONFIRMATION] ☐ Confirmation of rapid non-negative drug screen – [OMRAPIDCONFIRMATION] ☐ Collection only drug screen – [OMCOLLECTONLY] Lab: _____ Panel/Type of test: _____ ☐ Direct observation of urine collection – [OMDIRECTOBSERVE]	☐ DOT breath alcohol test (BAT) – [OMDOTBAT] ☐ 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)