



# AUTHORIZATION FOR SERVICES

Employee / Applicant: \_\_\_\_\_

Corporate Bill

Company Name: Firstlight Homecare - Self Pay Account , #24503376

Self Pay

Company Address: 2441 W DR 426, Suite 1011 Oviedo, FL 32765 **407-434-0675**

Worker's Compensation	Urine Drug/Alcohol Screening *	Exams
<input type="checkbox"/> Injury Treatment <input type="checkbox"/> Post Accident Drug Screen <input type="checkbox"/> DOT <input type="checkbox"/> Florida DFWP <input type="checkbox"/> Non-regulated <input type="checkbox"/> Post Accident Alcohol Testing <input type="checkbox"/> DOT Breath Alcohol <input type="checkbox"/> Florida DFWP Blood Alcohol <input type="checkbox"/> Non-regulated <input type="checkbox"/> Breath <input type="checkbox"/> Blood <p><i>NOTE: DOT post-accident testing requires breath alcohol. DFWP requires blood</i></p>	<p style="text-align: center;"><b>Reason for test</b></p> <input type="checkbox"/> Pre-employment <input type="checkbox"/> Random <input type="checkbox"/> Reasonable Cause <input type="checkbox"/> Post Accident <input type="checkbox"/> Return to Duty <input type="checkbox"/> Follow-up Observed Collection ** Yes _____ No _____	<input type="checkbox"/> Physical Exam <input type="checkbox"/> Annual/Periodic <input type="checkbox"/> Pre-employment <input type="checkbox"/> DOT Physical Exam <input type="checkbox"/> Annual/Periodic <input type="checkbox"/> Pre-employment <input type="checkbox"/> Respiratory Physical <input type="checkbox"/> Other: _____ <input type="checkbox"/> Osha Questionaire
	<p style="text-align: center;"><b>Urine Drug Screens *</b></p> <input type="checkbox"/> Collection only <input type="checkbox"/> Forms/kits on file in center <input type="checkbox"/> Employee will bring in form/kit <input type="checkbox"/> Florida Drug Free Workplace <input type="checkbox"/> 5 Panel <input type="checkbox"/> 8 Panel <input type="checkbox"/> 10 Panel <input type="checkbox"/> DOT Drug Screen Agency: _____ <input type="checkbox"/> Non-regulated Drug Screen	<p style="text-align: center;"><b>Occupational Testing</b></p> <input type="checkbox"/> Spirometry - Pulmonary Function <input type="checkbox"/> Audiometry <input type="checkbox"/> Titmus <input type="checkbox"/> Flu Shot <input type="checkbox"/> <b>PPD - TB Screening</b> <input type="checkbox"/> Hep Screening (HBSAB) <input type="checkbox"/> Hepatitis B Vaccine <input type="checkbox"/> EKG <input type="checkbox"/> <b>Chest Xray 1 view</b>
<p style="text-align: center;"><b>Prescription Dispensing Program:</b></p> May we fill W/C Prescriptions on-site? <input type="checkbox"/> Yes <input type="checkbox"/> No	<p style="text-align: center;"><b>Additional Notes/Comments:</b></p> <p style="background-color: yellow;">This is a SELF PAY only account. RESULTS go the patient. DO NOT BILL THE EMPLOYER</p>	<p>* Requires Photo Identification            ** Observed specimen collections require supporting documentation and can only be ordered under specific conditons</p>
<p style="text-align: center;"><b>Alcohol Testing *</b></p> <input type="checkbox"/> DOT Breath Alcohol Test <input type="checkbox"/> Non-DOT Breath Alcohol Test <input type="checkbox"/> DFWP Blood Alcohol <input type="checkbox"/> Non-Regulated Blood Alcohol		

Authorized by: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_

Phone Auth From: \_\_\_\_\_ Received by: \_\_\_\_\_ Date: \_\_\_\_\_ Time: \_\_\_\_\_