MACON OCCUPATIONAL MEDICINE

124 Third Street
Macon, Georgia 31201
Phone: (478) 751-2900
Fax: (478) 751-2979
Monday - Friday 7:30 a.m. - 5:00 p.m.

AUTHORIZATION FOR EXAMINATION OR TREATMENT

(MUST PRESENT PHOTO ID AT TIME OF SERVICE)

Employee Name:_____ SSN:_____

Company Name:_____ Date of Birth:_____

Street Address:_____ Location #:_____

Phone #:_____ Date:_____ Time:_____

By signing this form, I am authorizing treatment and appropriate injury management by our medical staff for the above employee. Authorization includes physician intervention, diagnostic testing, physical therapy and medications if indicated by the treating physician along with all non-work related injury care.

For work related injuries, I understand that is my ultimate responsibility to notify my insurance carrier of the employee's injury in order to establish a claim under workers' compensation and assure procedures and payment per Georgia's Workers' Compensation Act. If this claim is determined to be a non-work related injury/illness, I also understand that I am responsible for ALL BILLS generated by this claim until I inform Macon Occupational Medicine in writing of when the claim is being controverted.

For all billing, Payment is to be made within 30 days of receipt of the bill. If payment is not made, then a 10% penalty will be added at 30 and 60 days.

Authorized By: _____ Email: _____
(Please Print)

Signature: _____ Date: _____

INJURY TREATMENT

Date of Injury:_____ Time of Injury:_____

Please Briefly Describe Injury:_____

_____

SUBSTANCE ABUSE TESTING - ONLY

- ❑ Pre-Employment
- ❑ Post-Accident
- ❑ Reasonable Suspicion
- ❑ Random
- ❑ Return to Duty
- ❑ Follow-up

- ❑ Quick Test - 5 Panel
- ❑ Quick Test - 8 Panel
- ❑ Quick Test - 10 Panel
- ❑ Oral Fluid - 6 Panel
- ❑ Hair - 5 Panel
- ❑ Hair Collection
- ❑ Non DOT Collection
- ❑ 5 Panel
- ❑ 7 Panel
- ❑ 10 Panel
- ❑ Breath Alcohol
- ❑ Nicotine

DEPARTMENT OF TRANSPORTATION (DOT)

- ❑ Pre-Employment DOT Physical
- ❑ Re-Certification DOT Physical
- ❑ Follow-up DOT Physical

DOT SUBSTANCE ABUSE TESTING

- ❑ Random
- ❑ Post Accident
- ❑ Reasonable Suspicion
- ❑ Pre-Employment
- ❑ Follow-up
- ❑ Return to Duty

- ❑ DOT/MOM MRO
- ❑ Breath Alcohol Test
- ❑ DOT Collection

SPECIAL PHYSICAL EXAMINATION

- ❑ Respirator
- ❑ Return to Work
- ❑ Asbestos
- ❑ Annual
- ❑ Fit for Duty
- ❑ Hazmat
- ❑ Other:_____

PRE-EMPLOYMENT EVALUATION

- ❑ Physical Exam
- ❑ Post-Offer Placement / Agility Test

OTHER SERVICES

- ❑ Audiometry
- ❑ Visual Acuity
- ❑ Spirometry / PFT
- ❑ Respirator Questionnaire
- ❑ Respirator Fit Test
- ❑ Hepatitis B Shot 1st 2nd 3rd Shot
- ❑ TB Skin Test
- ❑ X-Ray(s) (Type:_____)
- ❑ Hepatitis B Titer
- ❑ Background Check
- ❑ MVR
- ❑ MMR Titer
- ❑ Varicella Titer
- ❑ Other:_____

BILLING INFORMATION

- ❑ Employee to pay charges at time of service
- ❑ Employer/Company to pay charges
- ❑ Workers' Compensation

Insurance Co.:_____

Claims Address:_____

_____

Phone #:_____

Claim #:_____

(copies of this form available at http://www.maconoccmedicine.org)