

EMPLOYER AUTHORIZATION FOR SERVICES

- | | | | | | |
|---|---|---|--|---|--|
| <input type="checkbox"/> Westchase
11969 Sheldon Rd. | <input type="checkbox"/> South Tampa
3301 W. Gandy Blvd. | <input type="checkbox"/> Carrollwood
4505 Gunn Hwy | <input type="checkbox"/> Wesley Chapel
5504 Gateway Blvd. | <input type="checkbox"/> Brandon
799 W. Lumsden Rd. | <input type="checkbox"/> Tyrone
3251 66 th St. N. |
| <input type="checkbox"/> Seminole
7601 Seminole Blvd. | <input type="checkbox"/> Sun City Center
16521 US Hwy 301 S. | <input type="checkbox"/> Fish Hawk
5464 Lithia Pinecrest Rd. | <input type="checkbox"/> Apollo Beach
6182 N. US Hwy 41 | <input type="checkbox"/> Apollo Beach
6182 N. US Hwy 41 | <input type="checkbox"/> Riverview
11406 US Hwy 301 S. |
| <input type="checkbox"/> Tarpon Springs
40545 US 19 th N | <input type="checkbox"/> Downtown at the Heights
303 W. Palm Ave. | <input type="checkbox"/> Downtown on Water Street
564 Channelside Dr. | <input type="checkbox"/> Trinity at Starkey Ranch
13531 State Rd. 54 | <input type="checkbox"/> 4th Street
4949 4 th Street N. | |

Employee Name: _____ Employee Date of Birth: _____

Employer Name: _____

Employer Address: _____

Employer Phone Number: _____ Contact Name: _____

Existing Account: Yes No Would you like us to contact you to set up an account? Yes No

Choose Bill To

- | | | |
|---|---------------------|--|
| <input type="checkbox"/> Employee Self Pay | | |
| <input type="checkbox"/> Employer Paid | Attention To: _____ | Via (email, fax, mailing address): _____ |
| <input type="checkbox"/> Workers Compensation | Carrier: _____ | Contact Information: _____ |

Workers Compensation

- Injury Treatment-Date of Injury: _____
- Post-Accident Drug Testing *(If urine drug screening is required, please complete section below)*
- WC Claim Number: _____
- Insurance Used: _____
- Post-Accident Alcohol Testing Breath Screen
- Saliva Screen Other: _____

Physical Examination Needed

- Select Type of Physical Required:
- Pre-employment
- DOT Physical
- U.S. Coast Guard (Form Required)
- None
- Other: _____

Urine Drug Screening Needed

- | | |
|--|--|
| Select Type of Screen Required (Select One Only): | Select Reason for Screen: |
| <input type="checkbox"/> Rapid 5-panel | <input type="checkbox"/> Pre-employment |
| <input type="checkbox"/> DOT | <input type="checkbox"/> Reasonable Suspicion/Cause |
| <input type="checkbox"/> Traditional Non-DOT | <input type="checkbox"/> Follow-up |
| <input type="checkbox"/> Single Cup 5-panel | <input type="checkbox"/> Workers Compensation Injury |
| <input type="checkbox"/> Single Cup 10-panel | <input type="checkbox"/> Random |
| <input type="checkbox"/> Split Cup 5-panel | <input type="checkbox"/> Return to Duty |
| <input type="checkbox"/> Split Cup 10-panel | <input type="checkbox"/> Other: _____ |

Titers Needed

- Select Type:
- Hepatitis A Hepatitis B
- MMR Varicella
- None
- Other: _____

Vaccinations Needed

- Select Type:
- Hepatitis A Hepatitis B
- MMR Varicella
- Tetanus – TD PPD-TB
- 2-Step PPD None
- Other: _____

Additional Services Needed

- Select Type:
- EKG Urinalysis
- Chest X-Ray L-Spine X-Ray
- Breath Alcohol Screening
- None
- Other: _____

I authorize TGH Urgent Care powered by Fast Track to treat the employee listed above for the services selected.

Revised 10/2021©

Authorized Designated Employee Representative _____ Date _____

TGH Urgent Care powered by Fast Track reserves the right to refuse treatment without employer authorization. Services provided without proper authorization will be billed as the patient's responsibility. Services may vary by location. To confirm services and availability, please contact TGH Urgent Care powered by Fast Track at 813-925-1903.