

Date: _____ **Patient Name:** _____ **SS#:** _____ - _____ - _____

Employer:			
Employer Phone:		Employer Fax:	
Employer Address:			
Primary Contact:			
Employer E-mail:			

Authorized services for today's visit (select all that apply).

Employee must bring this completed form for services to be rendered

Drug Screen- What is the reason? _____

 Type: 6 Panel Rapid In-House (OM015) 10 Panel Rapid In-House (OM016)

Send Out to Reference Lab
 DOT (OM017) Non-DOT (OM017) Hair Follicle Test (OM006)

 DOT with Twin River's CCF (OM018) Non-DOT with Twin River's CCF (OM018)

Alcohol Screen- What is the reason? _____

 Type: DOT Breath Alcohol Test (OM003) Non-DOT Breath Alcohol Test (OM003) Saliva (OM001)

Physicals-

 Type: DOT Physical (OM007) Pre-Employment/Non-DOT Physical (OM008)

Respirator Services-

 Type: Questionnaire Evaluation (OM021) Medical Exam (OM022) Spirometry Test (OM014)

Respirator Mask Fit Test
 Quantitative (OM020) Qualitative (OM020)

Other Testing-
 Audiogram (OM002)
 TB Skin Test with Read (OM051)

Titer Blood Draw
 MMR (OM043) Hep B (OM044)
 Varicella (OM045) QuantiFERON Gold Lab Test (OM056)

Special Instructions/ Other Testing Not Listed:	
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Billing Information

- Bill Established Employer Account (account must be current- no past due balance)
- Bill New Credit Card (See Next page)

Employer: *This certifies that the above information is correct. I authorize the medical provider to provide medical treatment to the employee named above. I also understand that the services provided will be paid in full by the company listed above and authorized by my signature below*

X _____
 Employer Signature (Required) Date Printed Name (Required) Title

Internal Office User Only

Admissions Staff Name:	Clinical Staff Name:	Location:
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Credit Card Authorization Form

Card Type: Visa MasterCard Discover American Express

Name on Card: _____

Card Number: _____

Expiration Date: _____

3 Digit Security Code: _____

Card Billing Address: _____

City: _____ State: _____ Zip Code: _____

I, _____, authorize Twin Rivers Health Care to charge my credit card for the agreed upon services. I understand that my information will be saved to file for future transactions on my account.

Card Holder Signature_____
Date

Locations:

Grand Island

**Twin Rivers Sports Medicine
& Family Medicine**

720 N. Webb Rd
Grand Island, NE 68803
Phone: 308-395-7700
Fax : 308-395-7713

Office Hours

Monday – Thursday 8am – 5pm
Call Ahead for Appointment 308-395-7700

Grand Island After Hours Location**Twin Rivers Urgent Care**

750 Allen Drive
Grand Island, NE 68803
Ph: 308-384-2500
Fax: 308-384-2565

Office Hours

Monday – Friday 8am – 8pm
Saturday 9am – 6pm
Sunday Noon – 5pm

Hastings

Twin Rivers Urgent Care

3203 Osborne Dr West, Ste 101
Hastings, NE 68901
Phone: 402-834-1005
Fax: 402-303-1022

Office Hours

Monday – Friday 8am – 8pm
Saturday 9am – 6pm
Sunday Noon – 5pm

Seward

**Twin Rivers Urgent Care &
Family Care**

510 Bradford St
Seward, NE 68434
Phone: 531-727-2893
Fax : 531-727-2896

Office Hours

Monday – Friday 8am – 5pm

Visit Us Online @

www.trurgentcare.com