PARKMed Urgent Care

www.parkmedurgentcare.com

**No.of Employees:** _____

## Company Protocol Information

**Date Completed:** _____

Please take a moment to fill out these pages entirely. It will help us to better serve the needs of your company.

Company Name: _____

Physical Address: _____

_____

Phone Number: _____ Fax: _____

Contacts: 1) _____ Ph: _____

2) _____ Ph: _____

3) _____ Ph: _____

Email address: _____

Does your company use a Third Party Administrator (TPA) for occupational medicine services? ☐ Yes ☐ No

If yes, list name of TPA: _____

Contact: _____ Ph: _____

Do you have a secure fax that results may be reported to? Secure Fax:: _____ Attention: _____

If so, you may omit the portions to follow regarding reporting of results and all will be reported to the above fax number.

## Services

What services does your company wish to utilize? (check all that apply)

☐ Drug screening ☐ Physicals ☐ Breath alcohol testing ☐ Audiometry ☐ Spirometry ☐ X-rays

☐ Drug screen consortium (DOT and non DOT) ☐ Workers' compensation services ☐ Primary care services

☐ Other (please list): _____

## Drug Screening

Please check the types of drug screens you require: ☐ Pre-employment ☐ Post-accident ☐ Random ☐ Other: _____

Will we be conducting full drug screens using our forms and lab, or does your company have your own contracted lab? ☐ PMUCC's lab ☐ Own lab

If we are only doing the drug screen collections, will your employee bring in forms, or will PMUCC have them on hand? ☐ Bring in ☐ On hand

**If we are using our forms and lab, please fill out the following questions completely:**

Is this DOT or non-DOT? ☐ DOT ☐ non-DOT (Contact us to customize a panel to meet your needs. There are many available panels consisting of the basic 5, 9, and 10 panels or panels that will even include hydrocodone, oxycodone, or other synthetics. )

Do you want to be contacted by phone with all results or just positive results? ☐ All results ☐ Positive results

Please list contact name(s) for drug screen results: _____, _____ _____.

To whom do we mail all drug screen results? _____

## Breath Alcohol Testing

Please check the types of breath alcohol tests you require: ☐ Pre-employment ☐ Post-accident ☐ Random ☐ Other: _____

Please list contact name(s) for breath alcohol results: _____, _____, _____.

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## Physicals

DOT physicals or non-DOT (company) physicals: ☐ DOT ☐ Company
If DOT physicals do you want us to give the original card and results to the driver or mail them to your company?
☐ Give to driver ☐ Mail to company, Attn: _____
If non-DOT, does your company have physical forms, or do we use our forms?
☐Company has own ☐ Use PMUCC's forms
To whom do we mail physical results? _____

## Additional Services

Please list all the additional services your company requires (please include protocol):

_____
_____

## Workers' Compensation Services

Please check if you are a member of "Tennessee Drug Free Workplace" ☐
Whom do we call to verify employment? _____ Ph: _____
Does your company require a post-accident drug screen? ☐ Yes ☐ No
Does your company require a post-accident breath alcohol test? ☐ Yes ☐ No
Does your company have medical report and duty status forms, or would you like us to use our forms?
☐Company has own ☐ Use PMUCC's forms
Would you like PMUCC to use our own in-house pharmacy for medications, or would you like us to write prescriptions for medications?
☐ In-house ☐ Write prescription
To whom do we mail medical report and duty status forms? _____
Whom do we call if a referral is needed? _____ Ph: _____
Please list name of your Workers' Compensation Insurance Carrier:
_____ Ph: _____

## Billing Information

### Occupational Medicine Billing Address (drug screens, physicals, etc.):

Co Name: _____
Addr: _____
_____
Phone No: _____ Fax: _____
Billing Contact: _____ Ph: _____

### Workers' Compensation Billing Address:

☐ Company ☐ Insurance carrier
Co Name: _____
Addr: _____
_____
Phone No: _____ Fax: _____
Billing Contact: _____ Ph: _____

## Clinic Location

Blount County
117 Gill Street
Alcoa, TN 37701
(865) 982-3409

## Additional Information

Please list any information that will help us to better serve your account:

_____
_____

How did you hear about Park Med Urgent Care Center (optional) _____.

Once complete, please fax this form to 865-560-8929
If you have questions, please call 865-985-7084. Thank you.

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**Agreement of Understanding**
**Payment Policy for Occupational Medicine Billing**

Thank you for choosing Park Med Urgent Care Center for your occupational medicine and worker's compensation needs. We are committed to fulfilling the needs and requests of all our Corporate Clients. In order to better serve our clients, Park Med Urgent Care Center has instituted the following payment policy for our occupational medicine billing.

Please note that all occupational medicine charges are due in full upon receipt of the invoice. We invoice our occupational medicine accounts on a monthly basis. After 30 days, if the invoice still has not been paid, you will receive a past due invoice. If the invoice remains unpaid after 120 days, your account will be considered delinquent and we may pursue collection of the account and hold you responsible for the costs of such collection, including attorney's fees. If you have questions regarding your invoice, contact our corporate office immediately. Our phone number for billing issues is (865) 985-7084.

Signing this agreement does not constitute a contract for the provision of services. This is a notice and acknowledgment of our policies and procedures for occupational medicine billing. Please sign this agreement and fax to (865)-560-8929. This agreement may also be mailed to the following address:

**Park Med Urgent Care Center**
**Corporate Office**
1431 Centerpoint Blvd, Suite 100
Knoxville, TN 37932

_____ _____
Authorized Signature Date

_____
Print Name/ Title