

Employer Authorization for Services: Clinic



Please give this completed form to Lake Region Healthcare at the time of registration.

This form will serve as authorization to treat the employee listed below for the services selected. If the patient requests or approves any additional services to be performed during their visit, those charges will be billed to the patient or the patient's insurance.

Employee Name: _____

Employer: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Contact Person: _____

Authorized Employer Signature: _____

Post Accident

- Post Accident Drug Testing
- Post Accident Alcohol Testing

Testing Vaccines

- Flu
- Hepatitis A
- Hepatitis B
- Tetanus
- Other: _____

Special Exams

- DOT Exam
- Pre-Employment Physical Exam
- Flight Exam
- Other: _____

Ancillary Services

- Spirometry
- Audiometry
- Vision Exam
- X-Ray
- Other: _____