

**Occupational Health Network**

**Company Profile Registration**

**PLEASE READ**: For scheduled pre-employment services, when a patient does not cancel with adequate notice (48 hours) or fails to show for an appointment, the employer will be charged a flat fee of $75. ***Employee/Patient actions affect our clinics and patients in multiple ways. The employer and employee do not receive the medical treatment needed, and/or another patient who requires medical treatment is unable to take that appointment slot.***

**Clinic(s) to be most utilized:**

Boise-Emerald  Nampa  Caldwell  Fruitland

Do you plan to use the Saint Alphonsus - Treatment Referral Form? Choose an item.

*If yes, we will provide those electronically and or hard copy upon request.*

**Company:** Click or tap here to enter text.

**Address:** Click or tap here to enter text.

**City:** Click or tap here to enter text.

**State:** Click or tap here to enter text.

**ZIP:** Click or tap here to enter text.

**Phone**: Click or tap here to enter text.

**Fax**: Click or tap here to enter text.

**Company email (Operational/Occ Med updates):** Click or tap here to enter text.

**Number of employees:**  Click or tap here to enter text.

**Workers Compensation Insurance Carrier Idaho (Surety):** Click or tap here to enter text.

Adjuster: Click or tap here to enter text. Phone:Click or tap here to enter text.

**Workers Compensation Insurance Carrier Oregon (Surety):** Click or tap here to enter text.

Adjuster: Click or tap here to enter text. Phone:Click or tap here to enter text.

**Commercial Health Insurance:** Click or tap here to enter text.

**Return to Work, Case/Claim contact person:** Click or tap here to enter text.

**Phone**: Click or tap here to enter text.

**Email**: Click or tap here to enter text.

**2nd** **Case/Claim contact person:** Click or tap here to enter text.

**Phone**: Click or tap here to enter text.

**Email**: Click or tap here to enter text.

Do you plan to use the Saint Alphonsus – Return to Work (RTW) Form? Choose an item.

Preferred case/claim correspondence method? Choose an item.

If fax, please provide fax number if different from above.

**Fax**: Click or tap here to enter text.

**Drug/Alcohol Screening**

Do you plan to use the Saint Alphonsus as a drug/alcohol screening provider? Choose an item.

**If NO,** please skip to signature line.

**If YES,** In order to do drug screening/testing, a Drug/Alcohol Testing Policy is required.

Can we reference the drug screening policy in clinic? Choose an item.

Do you plan for Saint Alphonsus to be a “collection only” site? Choose an item.

**If NO,** please complete the following section

**If YES,** please skip to “Collection Only” section.

**Drug and Alcohol Screening Service**

Please select the Drug/Alcohol services needed.

Pre-employment  Post Accident  Reasonable Cause  Random

**Please indicate the collection and testing type.**

Instant Drug Screen (non-DOT) 5 Panel  Cost: $40

- Further confirmation & Lab Work (if required) Lab Costs: $45

Standard Drug Screen (non-DOT) 5 Panel  Cost: $50

**Drug/Alcohol Screening contact person:** Click or tap here to enter text.

**Phone**: Click or tap here to enter text.

**Email**: Click or tap here to enter text.

**Collection Only Service** Cost: $35.00

Can we reference your chain of custody in clinic? Choose an item.

Please share the name of the reference lab:Click or tap here to enter text.

Who should be invoiced for collection services? Choose an item.

**If third party, please provide:**

**Company:** Click or tap here to enter text.

**Address:** Click or tap here to enter text.

**City:** Click or tap here to enter text.

**State:** Click or tap here to enter text.

**ZIP:** Click or tap here to enter text.

**Phone**: Click or tap here to enter text.

**Contact:** Click or tap here to enter text.

**Please share any comments, concerns, or questions below:**

**With the signature below we accept the service and “No Show, Late cancellation” policy above.**

Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SAMG Rep: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date Click or tap to enter a date. Date Click or tap to enter a date.

Date forwarded to clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_