Comprehensive Care
Occupational Medicine Specialists

7501 West 15th Avenue
Gary, IN 46406
Phone #: (219) 977-2090
Fax #: (219) 977-2091

Company Profile Information

(Please Complete and Return)

Company Name: _____ **Tax ID:** _____

Address: _____ **Phone:** _____

_____ **Fax:** _____

Contact Name: _____ **Email:** _____

Business Type: _____ **# of Employees:** _____

Emergency Contact: _____ **Cell Phone #:** _____
(for contact before or after hours)

General Information:

Individuals approved for Authorizing Services:

Contact Person: _____ 2nd Contact: _____

Position: _____ Position: _____

Contact #: _____ Contact: _____

3rd Contact: _____ 4th Contact: _____

Position: _____ Position: _____

Contact #: _____ Contact: _____

Drug Screening Information:

☐ Employee will bring in the chain of custodies

☐ Comp. Care will stock our chain of custodies

Who will supply Hair Kits? ☐ Comp. Care ☐ Company

Do you want Comprehensive Care to administer your Random Drug Screen Program? ☐ Yes ☐ No

Frequency of Random Program? ☐ Monthly ☐ Quarterly ☐ Other: _____

Basic Information:

Will you require assistance in afterhours care? ☐ Yes ☐ No

Is there the potential for you to utilize on-site services? ☐ Yes ☐ No

Services: _____ _____ _____

_____ _____ _____

Do you utilize any company specific forms? ☐ Yes ☐ No

Forms: _____ _____ _____

_____ _____ _____

Worker's Comp. Injuries: (insurance information must be provided)

Who will we bill for services? ☐Company ☐Insurance

Company Billing Information

Company Name:_____

Contact:_____

Address:_____

_____

Phone #:_____

Fax #:_____

Worker's Comp Insurance Information

Company:_____

Address:_____

_____

Contact:_____

Phone #:_____

Fax #:_____

Policy #:_____

Renewal Date:_____

Who will the physician contact for an initial injury?

Contact Person: _____

Phone #: _____

Cell Phone #: _____

2nd Contact: _____

Phone #: _____

Cell Phone #: _____

Who do we contact for approval for outside referrals?

Contact Person: _____

Phone #: _____

Cell Phone #: _____

2nd Contact: _____

Phone #: _____

Cell Phone #: _____

Injury Management Reports Send To:

☐ Fax #:_____

☐ eMail:_____

What post-accident drug / alcohol screens will we perform on your behalf?

☐DOT 5 Panel
☐10 Panel
☐Hair Collection ___5 panel ___10 panel
☐Breath Alcohol Test
☐Non DOT 5 Panel
☐10 Panel w/Alcohol
☐Test Cup (quick test)
☐Collection Site Only*
- ☐BCRC
- ☐MOST
- ☐DISA
- ☐ASAP
- ☐Forward Edge
- ☐CDS
- ☐Other:_____

Bills Send To:

Company Name:_____

Contact:_____

Address:_____

_____

Phone #:_____

Fax #:_____

Send To:

☐ Fax:_____

☐eMail:_____

*** Fax must be confidential**

What type of physicals will we perform on your behalf?

Pre-Employment

- ☐ Basic Physical
- ☐ DOT Physical
- ☐ Audio Test ☐ STS
- ☐ Pulmonary Function
- ☐ Respiratory Cert.
- ☐ Fit Testing
- ☐ X-Ray
- ☐ EKG
- ☐ Immunization
  - ☐ HepB
  - ☐ TB
  - ☐ Tetanus
  - ☐ _____
  - ☐ _____
- ☐ Lab Work / Screenings
  - ☐ _____
  - ☐ _____
  - ☐ _____
  - ☐ _____
  - ☐ _____
  - ☐ _____
  - ☐ _____
  - ☐ _____
- ☐ Assessments
  - ☐ Lift Test _____
  - ☐ Full Ergonomic
- ☐ DOT 5 Panel
- ☐ 10 Panel
- ☐ Hair Collection __5 __10
- ☐ Breath Alcohol Test
- ☐ Non DOT 5 Panel
- ☐ 10 Panel w/Alcohol
- ☐ Test Cup (quick test)
- ☐ Collection Site Only*
  - ☐ BCRC
  - ☐ MOST
  - ☐ DISA
  - ☐ ASAP
  - ☐ Forward Edge
  - ☐ CDS
  - ☐ Other:_____

Annual / Basic

- ☐ Basic Physical
- ☐ DOT Physical
- ☐ Audio Test ☐ STS
- ☐ Pulmonary Function
- ☐ Respiratory Cert.
- ☐ Fit Testing
- ☐ X-Ray
- ☐ EKG
- ☐ Immunization
  - ☐ HepB
  - ☐ TB
  - ☐ Tetanus
  - ☐ _____
  - ☐ _____
- ☐ Lab Work / Screenings
  - ☐ _____
  - ☐ _____
  - ☐ _____
  - ☐ _____
  - ☐ _____
  - ☐ _____
  - ☐ _____
  - ☐ _____
- ☐ Assessments
  - ☐ Lift Test _____
  - ☐ Full Ergonomic
- ☐ DOT 5 Panel
- ☐ 10 Panel
- ☐ Hair Collection __5 __10
- ☐ Breath Alcohol Test
- ☐ Non DOT 5 Panel
- ☐ 10 Panel w/Alcohol
- ☐ Test Cup (quick test)
- ☐ Collection Site Only*
  - ☐ BCRC
  - ☐ MOST
  - ☐ DISA
  - ☐ ASAP
  - ☐ Forward Edge
  - ☐ CDS
  - ☐ Other:_____

DOT

- ☐ DOT Physical
- ☐ Audio Test ☐ STS
- ☐ Pulmonary Function
- ☐ Respiratory Cert.
- ☐ Fit Testing
- ☐ X-Ray
- ☐ EKG
- ☐ Immunization
  - ☐ HepB
  - ☐ TB
  - ☐ Tetanus
  - ☐ _____
  - ☐ _____
- ☐ Lab Work / Screenings
  - ☐ _____
  - ☐ _____
  - ☐ _____
  - ☐ _____
  - ☐ _____
  - ☐ _____
  - ☐ _____
  - ☐ _____
- ☐ Assessments
  - ☐ Lift Test _____
  - ☐ Full Ergonomic
- ☐ DOT 5 Panel
- ☐ 10 Panel
- ☐ Hair Collection __5 __10
- ☐ Breath Alcohol Test
- ☐ Non DOT 5 Panel
- ☐ 10 Panel w/Alcohol
- ☐ Test Cup (quick test)
- ☐ Collection Site Only*
  - ☐ BCRC
  - ☐ MOST
  - ☐ DISA
  - ☐ ASAP
  - ☐ Forward Edge
  - ☐ CDS
  - ☐ Other:_____

Return to Work

- ☐ Basic Physical
- ☐ DOT Physical
- ☐ Audio Test ☐ STS
- ☐ Pulmonary Function
- ☐ Respiratory Cert.
- ☐ Fit Testing
- ☐ X-Ray
- ☐ EKG
- ☐ Immunization
  - ☐ HepB
  - ☐ TB
  - ☐ Tetanus
  - ☐ _____
  - ☐ _____
- ☐ Lab Work /Screenings
  - ☐ _____
  - ☐ _____
  - ☐ _____
  - ☐ _____
  - ☐ _____
  - ☐ _____
  - ☐ _____
  - ☐ _____
- ☐ Assessments
  - ☐ Lift Test _____
  - ☐ Full Ergonomic
- ☐ DOT 5 Panel
- ☐ 10 Panel
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- ☐ Breath Alcohol Test
- ☐ Non DOT 5 Panel
- ☐ 10 Panel w/Alcohol
- ☐ Test Cup (quick test)
- ☐ Collection Site Only*
  - ☐ BCRC
  - ☐ MOST
  - ☐ DISA
  - ☐ ASAP
  - ☐ Forward Edge
  - ☐ CDS
  - ☐ Other:_____

Specialty Physicals Available: ☐ Asbestos ☐ HAZWOPPER ☐ Other:_____

PHYSICALS

Send To:

- ☐ Hand back to employee
- ☐ Fax:_____
- ☐ eMail:_____

*** Fax must be confidential**

Bills Send To:

Company Name:_____

Contact:_____

Address:_____

_____

Phone #:_____

Fax #:_____

DRUG SCREENS

Send To:

- ☐ Hand back to employee
- ☐ Fax:_____
- ☐ eMail:_____

*** Fax must be confidential**

Bills Send To:

Company Name:_____

Contact:_____

Address:_____

_____

Phone #:_____

Fax #:_____

What drug screens will we perform on your behalf?

Random

- ☐ DOT 5 Panel
- ☐ 10 Panel
- ☐ Hair Collection __5 __10
- ☐ Breath Alcohol Test
- ☐ Non DOT 5 Panel
- ☐ 10 Panel w/Alcohol
- ☐ Test Cup (quick test)
- ☐ Collection Site Only*
  - ☐ BCRC
  - ☐ MOST
  - ☐ DISA
  - ☐ ASAP
  - ☐ Forward Edge
  - ☐ CDS
  - ☐ Other:_____

Probable Cause

- ☐ DOT 5 Panel
- ☐ 10 Panel
- ☐ Hair Collection __5 __10
- ☐ Breath Alcohol Test
- ☐ Non DOT 5 Panel
- ☐ 10 Panel w/Alcohol
- ☐ Test Cup (quick test)
- ☐ Collection Site Only*
  - ☐ BCRC
  - ☐ MOST
  - ☐ DISA
  - ☐ ASAP
  - ☐ Forward Edge
  - ☐ CDS
  - ☐ Other:_____

NOTES:

_____

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Send To:

☐ Fax:_____

☐ eMail:_____

*** Fax must be confidential**

Bills Send To:

Company Name:_____

Contact:_____

Address:_____

_____

Phone #:_____

Fax #:_____

Questions About Drug Screens

Contact:_____

Title:_____

Phone #:_____

Fax #:_____

Cell #:_____

Ancillary Services?

Respirator Fit Testing

- ☐ Respiratory Certification
- ☐ One (1) Mask Fit Test
- ☐ Two (2) Mask Fit Test
- ☐ Three (3) Mask Fit Test
- ☐ Pulmonary Function Test
- ☐ Other:_____
- ☐ Other:_____
- ☐ Other:_____

Miscellaneous

- ☐ Audio Test
- ☐ Standard Threshold Shift
- ☐ Other:_____
- ☐ Other:_____
- ☐ Other:_____
- ☐ Other:_____
- ☐ Other:_____
- ☐ Other:_____

Lab Work

- ☐ Lead / ZPP
- ☐ Heavy Metals
- ☐ Benzine
- ☐ HEP B Titer
- ☐ HEP C Titer
- ☐ Other:_____
- ☐ Other:_____
- ☐ Other:_____

Immunizations

- ☐ Tetanus
- ☐ Flu Shot
- ☐ HEP B
- ☐ HEP B Series
- ☐ TB
- ☐ Other:_____
- ☐ Other:_____
- ☐ Other:_____

Bills Send To:

Company Name:_____

Contact:_____

Address:_____

_____

Phone #:_____

Fax #:_____

Information Send To:

☐ Fax:_____

☐ eMail:_____

*** Fax must be confidential**

Authorization of Services:

All employees sent to Comprehensive Care for medical care and services must have an authorization from their employer. The employer can use either their own authorization form or the form supplied by Comprehensive Care. Authorizations can be faxed or brought in by the employee or supervisor. Verbal authorizations will not be accepted unless a prior arrangement has been made.

Responsibility of First Visit Treatment:

The company ("Client") agrees to indemnify Comprehensive Care for fees incurred on initial visits at the clinic.

Billing & Collection Policy:

All Invoices distributed by Comprehensive Care or Comprehensive Physical Therapy are due upon receipt.

It will be **mandatory** for companies doing business with Comprehensive Care or Comprehensive Physical Therapy to supply their current workmen's compensation insurance information for storage on our computer database. Once services have been rendered and our invoices have been mailed, your company will have a 10 day grace period to decide whether or not your invoice will be paid directly or will be forwarded onto your insurance carrier. It is the responsibility of all self-insured clients to contact billing@compcareonline.com with your list of invoices designated for direct or insurance carrier payment.

Clients opting to directly have invoices forwarded to the worker's compensation insurance carrier must file an initial injury report within 7 days of injury in accordance with IC 22-3-4-13 and provide Comprehensive Care with a claim number for proper payment follow up within the 10 day grace period. After the 10 day grace period Comprehensive Care reserves the right to contact your insurance carrier for a claim approval number.

Additionally, Comprehensive Care reserves the right to file an application for adjustment of claim for provider fee with the Indiana Worker's Compensation Board for outstanding invoices aged 30 + days. The filing of the application begins a legal proceeding and as required by the Indiana Worker's Compensation Board, Comprehensive Care is required to obtain legal representation. Any attorney fees and costs incurred will be added to the outstanding balance.

All non-worker's compensation related invoices are due within 30 days. If payment is not received within said 30 day period, client will be assessed a late charge equal to 1 ½ percent of the unpaid amount per month.

Comprehensive Care and Comprehensive Physical Therapy reserve the right to suspend all services on accounts with outstanding balances that are greater than **30 days** until full payment is received or payment arrangements have been made with your company.

We must receive a copy of this signed billing and collection policy disclosure that will be kept in your company file for the duration of our business association.

Should it be necessary to assign the account balance to a collection agency or an attorney for legal action, all subsequent collection charges and reasonable legal fees shall be paid by the Client or Individual.

The Provider reserves the right to discontinue service to any Client or individual who has not complied with this policy as it relates to the payment for services rendered by the Provider.

Acknowledgement of Understanding:

- ✓ We have completed the Company Profile to the best of my / our abilities to ensure the procedures conducted are compliant with state and federal guidelines.
- ✓ I / We have read and understand Comprehensive Care's *Authorization of Service* and *Billing & Collection Policies.*
- ✓ I / We have kept a copy of the Company Profile for our own internal records.
- ✓ Any changes to the Company Profile will be notified to Comprehensive Care Immediately. This includes changes to procedures, contacts, results / reports destination & delivery, and billing information.

Comprehensive Care, Inc.	
Company Name	**Company Name**
Michael Pelz	
Contact Name (Please Print)	**Contact Name (Please Print)**
	
Signature	**Signature**
Date	**Date**

Credit Card Information:
If your company wishes to pay for services via credit card please complete the following section.

What services do you want to pay for via credit card?

- ☐ Physicals
- ☐ Drug Screening
- ☐ Worker's Comp. Injuries
- ☐ Pulmonary Function Testing
- ☐ Job Demand Analysis
- ☐ Respirator Certification
- ☐ Respirator Fit Testing
- ☐ Immunizations / Screenings
- ☐ Other:_____
- ☐ Other:_____

Card Type: ☐VISA ☐MasterCard ☐Discover ☐American Express

Cardholder's Name: _____

_____

Address: _____

_____

_____

Phone #: (__ __ __) __ __ __ - __ __ __ __

Credit Card #: __ __ __ __ - __ __ __ __- __ __ __ __ - __ __ __ __

Expiration Date: __ __ / __ __ __ __

Security #: __ __ __

Notes:_____