



BUSINESS HEALTH PARTNERS

“Partners With Business and Industry”

AUTHORIZATION FOR TREATMENT

Date: _____

Name of Company: _____

Representative Approving Treatment: _____

Jobsite Contact & Phone # for follow up on patient: _____

Patient Name: _____

DATE OF INJURY: _____

*This note authorizes the above patient to be seen and treated by Business Health Partners for the injury/illness which occurred on the above date.

****In the event of an after-hours fee, that is not paid 100% by the insurance company, the unpaid balance will be billed to your company for payment.***

Signature of Representative

Person to contact for further treatment: _____

Telephone/Fax Number _____

****Post Accident Testing Required (circle one) NA

Drug Screen NON DOT DOT

Breath Alcohol NON DOT DOT