

**North Fargo**

1100 19th Avenue N.  
 Fargo, ND 58102  
 (701) 364-5757 M-F 8am-4:30pm

**32<sup>nd</sup> Ave Emergency**

3000 32nd Avenue S.  
 Fargo, ND 58103  
 (701) 364-8900 Emergency and after-hours care

**Appointment Information**

Date: \_\_\_\_\_  
 Time: \_\_\_\_\_

**Patient Information**

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_

**Company Information**

Company: \_\_\_\_\_ Contact Name: \_\_\_\_\_  
 Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Guarantor Account #: \_\_\_\_\_ Email: \_\_\_\_\_  
 Department: \_\_\_\_\_

**Billing Information (Select One):**     Company Pay     ND WSI, claim # if available: \_\_\_\_\_

**Services Requested (Check all that apply):****Drug and/or Alcohol Testing**

<b>Custody and Control form:</b> (Choose one) <input type="checkbox"/> CCF on file at Essentia Health <input type="checkbox"/> Patient to present to clinic with CCF		
<b>Reason for Testing:</b> (Choose one)		
<input type="checkbox"/> Pre-employment	<input type="checkbox"/> Random	<input type="checkbox"/> Post-accident
<input type="checkbox"/> Reasonable Suspicion	<input type="checkbox"/> Annual	<input type="checkbox"/> Follow-up*
	<input type="checkbox"/> Other _____	<input type="checkbox"/> Return to Duty*
		<i>*Observed Collection</i>
<b>Testing to be completed:</b>		<b>PHOTO ID REQUIRED</b>
<input type="checkbox"/> 5 Panel Non-DOT Urine Drug Screen (Test code #90700)	<input type="checkbox"/> DOT Urine Drug Screen (collection only) - DOT Agency: _____	

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> <b>Audiogram</b>  | <input type="checkbox"/> <b>Vision Screen</b>                           | <input type="checkbox"/> <b>Immunizations:</b> | <input type="checkbox"/> <b>Labs:</b>  |
| <input type="checkbox"/> <b>PFT</b>  | <input type="checkbox"/> <b>Chest X-ray</b>                             | <input type="checkbox"/> Hep A                 | <input type="checkbox"/> UA Dip        |
| <input type="checkbox"/> <b>Respirator Clearance</b><br><small>OSHA Respirator Questionnaire review with Respirator Exam</small> | <input type="checkbox"/> <b>Respirator Fit Test</b><br>Mask Type: _____ | <input type="checkbox"/> Hep B                 | <input type="checkbox"/> Lipid Profile |
| <input type="checkbox"/> <b>Non-DOT Physical</b>   | <input type="checkbox"/> <b>DOT Physical</b>                            | <input type="checkbox"/> Tdap                  | <input type="checkbox"/> CMP           |
| <input type="checkbox"/> <b>Other Requested Service:</b> _____   |   | <input type="checkbox"/> Rabies                | <input type="checkbox"/> Lead          |
|  |   | <input type="checkbox"/> Influenza             | <input type="checkbox"/> Hep B Titer   |
|  |   | <input type="checkbox"/> Other _____           | <input type="checkbox"/> Other _____   |

**By signing below, Company is agreeing to the Terms and Conditions below.**

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_ Phone: \_\_\_\_\_

Signature: \_\_\_\_\_

Comments: \_\_\_\_\_

**Terms and Conditions**

1. Authorization. Company authorizes Essentia Health, or an Essentia Health affiliate, to provide the services as indicated.
2. Payment. Company agrees to pay Essentia Health's current rates for all services rendered within 30 days of invoice.
3. Compliance with Laws. Company and Essentia Health agree to comply with all applicable federal and state laws and regulations, including but not limited to HIPAA.
4. Use of Information. Company grants Essentia Health the right to retain and use information related to provision of the services, including but not limited to placing the information in Essentia Health's medical record system and providing patient with a copy of their information.
5. Indemnification. Each party shall indemnify and hold harmless the other party against all liability or loss, and against all claims or actions based upon or arising out of actions by the indemnifying party.
6. Confidentiality. Both parties will handle the other party's confidential information with reasonable care, and agree never to use or disclose such information except as permitted under this Authorization or as necessary to carry out obligations under this Authorization.
7. Governing Law. This Authorization shall be governed and construed in accordance with the laws of the state of Minnesota, without regard to the choice of law principles thereof.
8. Entire Agreement. This Agreement sets forth the entire understanding of the Parties and may only be modified in writing signed by both Parties.

**North Fargo:** Send completed form with your employee OR fax 701-364-5761 OR email [NorthFargoAuth@essentiahealth.org](mailto:NorthFargoAuth@essentiahealth.org)

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