HealthRoute

4985 Hoffner Avenue Suite 2
Orlando, FL 32812
Tel. 407-859-1880
Fax 844-748-0839

Account Set Up and Agreement

Start Date:________________________

Please check and initial the services you will need.

Service	Price	Initial
☐ DOT Physical	$69.00	Please Initial_________
☐ Federal Drug Test	$45.00	Please Initial_________
☐ Non-Federal Drug Test	$45.00	Please Initial_________
☐ Urine Collection only	$20.00	Please Initial_________
☐ Breath Alcohol Test (BAT)	$45.00	Please Initial_________
☐ BAT Confirmation	$45.00	Please Initial_________

Company Name:____

Company Physical Address:____

Company City, State, Zip:____

Company Phone #:____

Company Fax #:____

DER (Designated Employer Representative):________________________________

DER Phone# (cell):____

DER E-mail Address:____

How would you like us to transmit drug or alcohol test results to you? ☐ Fax ☐ Email

Preferred method of payment: (choose one)

☐ *Charge my credit card on file.

I, Authorize HealthRoute to charge my credit card for agreed upon purchases. I understand that my information will be saved for future transactions on my account.

☐ Prepay online. Go to HealthRoute.net and click on EMPLOYERS tab.

☐ Driver will bring payment on date of service. Checks are not accepted.

- Please provide an authorization form for any requested service.
- All Drivers must bring driver's license.
- Copy of Medical Examination Report and medical card will be provided to the driver after a DOT physical.

Credit Card Authorization Form

All information will remain confidential.

Credit Card Information

Card Type (Circle One) : MasterCard Visa Discover AMEX Other: ___________________

Cardholder Name: ____

Credit Card Number: ____

Expiration Date: ____CVV:______________

Cardholder Zip Code (from credit card billing address):___________________________________

Email:____ (receipt will be sent via email)

I authorize HealthRoute to charge the agreed amount for the services requested. I agree that I will pay for the services in accordance with the issuing bank cardholder agreement. I further authorize HealthRoute to keep my credit card information on file so that payments can be made at the time of service. I will provide my employees a signed AUTHORIZATION FOR SERVICE form. Finally, I will update HealthRoute with any changes to my credit card information.

Cardholder - Print Name, Sign and Date Below:

Name: ____

Signature: ____

Date: ____

Please fax the competed form to: HealthRoute (Do not email)
Fax: 844.748.0839

Authorization For Services

EMPLOYEE INSTRUCTIONS: Please bring this form with you when you come to HealthRoute. The office requires the information on this form in order to correctly process your test. Please note that failure to present this form to the office at the time of service may delay the processing of your test. **The company may also send us this form prior to the time of service if preferred.**

Person requesting service: ______________________________

Company name: ______________________________

Date of Authorization: ______________________________

Employee name: ______________________________

******Please answer items 1-3 below******

1. **Payment will be made by: Choose one**

   ☐ Company ☐ Employee

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2. Type of Service Requested: Choose one

☐ Federal/DOT ☐ Non-federal/Non-DOT (Employee not required to have CDL)

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3. Please specify the services you would like us to perform:

☐ DRUG SCREEN

Reason for test **(circle one)**:
pre-employment, random, post accident, reasonable cause, follow up

☐ BREATH ALCOHOL TEST

Reason for test **(circle one)**:
pre-employment, random, post accident, reasonable cause, follow up

☐ URINE COLLECTION ONLY (**employer provides chain of custody form)**

Reason for test **(circle one):**
pre-employment, random, post accident, reasonable cause, follow up

☐ DOT PHYSICAL EXAM

HealthRoute
4985 Hoffner Ave. Between Semoran Blvd and Conway Rd.
Walk-Ins Welcome M, T, TH, F : 9am-5pm and Wed 9am-1pm
Phone: 407.859.1880 Fax: 844.748.0839