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 .

☐ DOT Physical	$79.00	Please Initial_____
☐ Federal Drug Test	$55.00	Please Initial_____
☐ Non-Federal Drug Test	$55.00	Please Initial_____
☐ Urine Collection only	$35.00	Please Initial_____
☐ Breath Alcohol Test (BAT)	$55.00	Please Initial_____
☐ BAT Confirmation	$25.00	Please Initial_____

☐ Random Program membership (Please ask for random program signup form)

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 before sending employee for testing. 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 certify that I a the authorized holder and signer of the credit card referenced above. 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

---

2. Type of Service Requested: Choose one

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

---

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