

TOWER MEDICAL CENTER OF NEDERLAND

2100 Hwy 365

Nederland, TX 77627

Phone (409) 724-2321 / Fax (409) 729-7237 / www.towermedical.biz

The information set out below should be completed in order to set up a new account with TMN and updated annually in order to maintain up-to-date account information

COMPANY INFORMATION

Company Name: _____
Company Address: _____
City _____ State _____ Zip Code _____
Billing Address: _____
City _____ State _____ Zip Code _____

COMPANY CONTACTS

All contacts listed below can receive a copy of drug testing and medical results unless otherwise indicated.

Contact Name (Exam Results): _____
Email address: _____
Phone: () _____ Fax: () _____
Email Results to Contact: Yes No

Contact Name (DrugScreen/Testing Results) _____
Email address: _____
Phone: () _____ Fax: () _____
Email Results to Contact: Yes No

Contact Name (Injury Results): _____
Email address: _____
Phone: () _____ Fax: () _____
Email Results to Contact: Yes / No

ACCOUNTS PAYABLE INFORMATION

Any special job number, job location or PO number that should be listed on an invoice must be placed on each patient protocol sent to us.

Contact Name: _____
Email address: _____
Phone: () _____ Fax: () _____

CREDIT CARD INFORMATION

Credit Card Type: Master Card, VISA, AMX or Discover
Name on Card: _____
Credit Card Number: _____
Expiration Date: _____ Security Code: _____
A credit card MUST be on file with TMN.

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SERVICES TO BE PROVIDED

Indicate on the price/authorization sheet by checking the items you would like us to provide to your employees. The items you check will be placed on your specific company protocol that will be emailed to you when set up is complete. We must have a protocol / authorization on every employee you send in before we provide services.

INJURY CARE INFORMATION

If any injury is deemed non occupational, your company will be responsible for payment. Indicate your billing procedures for all injury care related services:

Directly to Company **Insurance Company** (complete below) **Case-by-Case Basis**

A credit card MUST be on file with TMN for Direct Billing.

When billing Case-by-Case, Company must inform TMN at the time of initial visit.

INSURANCE INFORMATION:

Insurance Carrier: _____

Insurance Address: _____

City _____ State _____ Zip Code _____

Agent Name/Phone: _____

IS LIGHT DUTY AVAILABLE? Yes No

DRUG SCREEN INFORMATION

List the type of tests that should be administered upon arrival of your injured employee:

Drug Screen **Breath Alcohol** **Hair Test** **None**

Will Dr. Lance Craig be your Medical Review Officer (MRO) for drug screening? Yes No

If NO, provide your Drug-Testing Consortium's information below.

Consortium Name: _____

Consortium Account #: _____

PAYMENT AGREEMENT

Payment Agreement (must be signed by owner or authorized agent/officer)

Tower Medical Center of Nederland (TMN) provides a courtesy option of billing services directly to the company. TMN requires that a protocol form that we provide to you be signed by an authorized company representative for any service provided. The signed protocol page will serve as an agreement between Company and TMN. Company agrees that all services rendered will be paid and attests to financial responsibility, ability and willingness to pay. Company agrees to pay TMN within 45 days from the date of the invoice; otherwise a late fee of \$30 may be assessed. Company agrees that if payment is not made within the time allowed AND after given the opportunity to cure default that TMN will: (1) Charge Company's credit card; OR (2) Bill Company's Insurance Carrier directly for injury related services provided during office hours (TMN will notify Company prior to initiating these actions). Company also agrees that if Insurance Carrier denies a claim due to Company's failure to act accordingly that Company will be responsible for payment.

Company Name: _____

Authorized Agent (please print): _____

Signature: _____ Date: _____

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PATIENT / EMPLOYER INFORMATION AUTHORIZATION

Patient Name	Date of Birth	Social Security #
Company Name		Company Address
Phone #	Fax #	PO# - Job#

Services Required – Injury Care

Date of Injury: _____ Injured Body Part: _____
 ___ Bill Company ___ Bill Insurance

Substance Abuse Testing:	
___ DOT	___ Non-DOT
___ Drug Screen collection (your lab)	\$ 12.00
___ Drug Screen - Non-DOT (our lab)	\$ 25.00
___ Drug Screen - Non-DOT w/ Urine Alcohol	\$ 30.00
___ Drug Screen - DOT w/MRO	\$ 45.00
___ Drug Screen - Stat Test	\$ 30.00
___ EBT – Breath Alcohol	\$ 25.00
___ EBT – Confirmation	\$ 20.00
___ Hair Follicle collection (your Lab)	\$ 15.00
___ Hair Follicle 5 panel (our lab)	\$ 100.00
___ Hair Follicle 10 panel (our lab)	\$ 150.00
___ MRO Fee (Dr. Lance Craig)	\$ 20.00

Physical Examination Requested:	
___ Standard Exam (our form 1 pg)	\$ 40.00
___ DOT Exam	\$ 80.00
___ Extended Exam (3 or more pg)	\$ 50.00
___ Asbestos Exam	\$ 50.00
___ Aniline Exam	\$ 50.00
___ Crane Operator Exam	\$ 50.00
___ Coast Guard Exam	\$ 50.00
___ Silica Exam	\$ 50.00
___ Return to Work Level I	\$ 50.00
___ Return to Work Level II	\$ 85.00
___ Other _____	

TESTING	
___ Audiometry	\$ 25.00
___ EKG	\$ 50.00
___ Fit Test _____	\$ 25.00
___ Fit Test _____	\$ 25.00
___ Flexion	\$ 15.00
___ PFT (Pulmonary Function Test)	\$ 25.00
___ Other _____	

VACCINE	
___ Hepatitis A	\$ 95.00
___ Hepatitis B (series of 3 injections)	each \$ 95.00
___ Tdap	\$ 60.00
___ Other _____	

X-RAY	
___ Chest PA (1 view)	\$ 75.00
___ Chest PA & LAT (2 view)	\$ 85.00
___ Lumbar (3 view)	\$ 100.00
___ Lumbar (5 view)	\$ 125.00

Laboratory	
___ Blood Benzene	\$ 75.00
___ CBC	\$ 25.00
___ Hemoccult	\$ 20.00
___ Lead / ZPP	\$ 45.00
___ Lipid Profile	\$ 30.00
___ Urinalysis	\$ 20.00
___ Urine Cytology	\$ 88.00
___ Urine Phenol	\$ 100.00
___ Lab Screen (CBC, CMP, Lipid)	\$ 85.00
___ Heavy Metal I (Arsenic, Barium, Beryllium)	\$ 375.00
___ Heavy Metal II (Arsenic, Cadmium, Lead, Mercury)	\$ 450.00

Price changes start 10/01/2018

Authorization (Authorized by):

Tower Medical Center of Nederland (TMN) provides our client companies with a courtesy option of billing services directly to your company. TMN DOES NOT have a contract with your insurance provider. TMN requires an authorization form signed by one of your company representatives for any service provided. This authorization form shall serve as a payment agreement between TMN and your company, not your insurance company. You are agreeing that all services rendered will be paid for by your company and that company attests to financial responsibility, ability and willingness to pay TMN invoices within 45 days from the date of invoice; otherwise a \$30 late fee may be assessed. Company also agrees that if your Insurance Carrier denies a claim due to your failure to act accordingly that company will be responsible for payment. **Note: A credit card MUST be on file with TMN**

Print Name	Date
Signature	Time