

Web: www.ahconline.com

Mailing Address: PO Box 1065, Lowell AR 72745

Account ID: *CLINIC USE ONLY*

COMPANY PROFILE FORM

ARKANSAS OCCUPATIONAL HEALTH CLINIC

Locations:

Springdale Clinic: 4001 Wagon Wheel Road, Springdale AR 72762 -- Exit 76 off I49 TEL 479-725-3001 FAX 479-725-3098

Russellville Clinic: 3127 West 2nd Court, Suite B, Russellville AR 72801 TEL 479-219-5190 FAX 479-358-9787

Van Buren Clinic: 2010 Chestnut St, Suite B, Van Buren AR 72956 (across from Summit Hospital) TEL 479-262-2724 FAX 479-262-2727

Any questions, contact Terry Guy, 479-725-3043, tguy@ahconline.com or Victoria Hernandez, 479-725-3008, vhernandez@ahconline.com

New Company **Company Update**

COMPANY NAME:		
Address:		
City:	State:	Zip:
Phone:	Fax:	(Secure Fax: <input type="checkbox"/> Yes <input type="checkbox"/> No)
# of employees:		

AUTHORIZED POINT OF CONTACTS <i>The following will be able to schedule appointments and receive results if requested</i>	
1. Name:	
Phone:	E-mail:
2. Name:	
Phone:	E-mail:
3. Local contact (if not listed above):	
Phone:	E-mail:

BILLING <i>Check one</i> <input type="checkbox"/> E-mail <input type="checkbox"/> Fax <input type="checkbox"/> Call for Credit Card <input type="checkbox"/> USPS		
Company:	Attention:	Phone:
E-mail:		
Fax:		
Address:	City:	State: Zip Code:

WORKERS COMP CARRIER:	Policy #:
Address:	
City:	State: Zip Code:
Phone:	Fax:
AOHC sends WC bills directly to WC insurance carrier indicated above unless marked below	
Work related injury bills send to: <input type="checkbox"/> Employer * ALL THE WC BILLING PER THE ARKANSAS FEE SCHEDULE	

OCCUPATIONAL SERVICES

DRUG SCREENS

- NO DRUG SCREENING DOT drug screens NonDOT drug screens Hair drug screens Rapid drug screen
 Our lab & MRO Collection only ___ You send in a supply of chains ___ Employee will bring chain

PHYSICALS

- NonDot physicals DOT physicals Respiratory physicals Hazmat physicals Police physicals

MISCELLANEOUS

- Audiogram Spirometry Mask Fit Test Breath Alcohol Screening EKG Chest X-ray
 TB Skin Test Hepatitis B injection Hepatitis B Titer Flu Vaccine

If not listed above, please indicate: _____

RESULTS SENT: **Secure Fax:** _____ **E-mail** _____

Signature: _____ Title: _____ Date: _____

Please complete, sign and return, authorizing AOHC to perform the services checked above.

FOR CONTACT INFORMATION ONLY- NOT A CONTRACT