SouthStar URGENT CARE Powered By: HULIN HEALTH

New Client Set Up Questionnaire

Company Information

All Contact information fields are required for us to provide the best service possible. Please add any additional notes for company communication in the “Additional Notes” Section.

Company Name:			
Employee Count:		Industry:	
Main Contact:		Title:	
Phone #:		Fax #:	
Email Address:			
Physical Address:			
After Hours Contact (After 5pm and weekends) same as main contact? YES ☐ NO ☐			
- If, NO please enter information below:			
After Hours Contact:		Title:	
Street Address:		Suite #:	
Phone #:			
City:	State:	Zip:	
Billing Address same as Physical Address?		YES ☐	NO ☐
- If NO, please enter Billing Address:			
Street Address:		Suite #:	
City:	State:	Zip:	
Phone #:		Fax #:	
Email Address:			
Is there anyone else at the company other than the main contact person that we can talk to for authorizations or if we have questions about your employees? YES ☐ NO ☐			
- If YES, please enter service authorization contact:			
Contact Name:		Title:	
Phone #:		Fax #:	
Email Address:			

How did you hear about us? Clinic ☐ Website ☐ Referral ☐ Community ☐ Signage ☐ - If you were referred, please share source name: ___________________________
Company Contact Additional Notes:

Setup: Workers' Comp

Will you be sending any injuries to us?	YES ☐	NO ☐
If YES, who will be receiving the bill for Workers' Comp visits?	Company ☐	Insurance ☐

If you selected Company, please complete the information below:

Name of Insurance Company:	
Phone #:	Fax #:
Address:	
Adjuster's Name:	Adjuster's Phone:

Setup: Results

Results of screenings can either be securely sent to clients via Email of Fax.
How would you like the results from each visit sent to you?

☐ Fax ATTN: ____________________________ Fax #: __________________________

☐ Email ATTN: ____________________________
Email Address ____ Password: _______________
Email password will need to be 6 or less characters and will be used to access emailed results from our clinic.

Use of Services: Authorization

Service authorization forms are required for each visit in order to receive services.
We require an authorization per employee for tracking purposes.

Does your company have its own Service Authorization form?		YES ☐	NO ☐
How will you be sending authorization forms?	With Employee ☐	Fax ☐	Email ☐

If email: please document clinic town location in the subject line i..e "LAFAYETTE CLINIC"

System Setup: Protocols

What kind of protocol would you like to set up with us? (Use Case)

What do you need for each protocol?	What type of drug screens do you require?
☐ Pre-Employment:	☐ DOT send off
☐ Randoms:	☐ Non-DOT send off
☐ Injuries/post accidents:	☐ 10 Panel quick test
☐ Other:	☐ 5 Panel quick test
☐ Other:	☐ Other:

☐ Other:	☐ Other:

Screening Setup: Drug Screens		
Does your company have their own forms for drug screens?	YES ☐	NO ☐
- If NO, will you be ok with using our forms which are through LabCorp?	YES ☐	NO ☐
Does your company have their own breath alcohol forms?	YES ☐	NO ☐
Does your company use DISA for any collections?	YES ☐	NO ☐
- If YES, will we be billing DISA for the collections?	YES ☐	NO ☐
Does your company use any other Third-Party Company that we will be billing for any part of your protocol?	YES ☐	NO ☐
- If YES what company? :		
- What will be billed to this company?		

Company Setup Additional Notes:

FOR OFFICE USE ONLY: Company Number:	
Onboarding Type: In person / Phone /	Protocol(s) Entered in System by:
Onboarding Email Sent:	Notes: