



1028 FORUM ROAD • BROUSSARD, LA 70518 • PHONE 337.704.0891 • FAX 337.704.0924

Physician Encounter Authorization Form

This form can be emailed or faxed to the clinic prior to sending the employee, or can be brought in with the employee at time of service. If patient arrives without the clinic having this information, a blank form will be provided at the clinic for completion by the supervisor or authorized person.

Employer Name:		Company Telephone:	
Patient Date of Birth:		Patient last 4 of Social:	
Patient Name			
Patient Complaint:		Personal or work related:	
Company responsible for today's fees:			If visit is personal, write SELF
Name of Billing Contact:		Billing Telephone:	
Billing E-Mail:			
Company Billing Address:			
Name of HSE Contact:		HSE Telephone:	
HSE E-Mail:			

I understand that by signing this form, I authorize XstremeMD to treat the above employee and the company above will be held responsible for payment of all fees incurred. If the visit is deemed personal after it has begun, the company is still liable for the charges.

*I understand that XstremeMD **DOES NOT** bill Workers Compensation, Medicare, Medicaid or private insurance. You are expected to pay XstremeMD for the invoice by the due date. If you have not set up a customer account with XstremeMD payment is due in 14 days. Failure to pay will result in your company no longer being seen in our clinics until payment is made.*

Signature* *required for new companies*

Printed Name

Date

Title

Check here if paying by credit card at time of service.