Protecting our partners' most valuable assets

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.

Company Information

Employer Name			Company Telephone	
Patient Name			DOB	Patient Last 4 of Social
Patient Complaint			Personal or Work Related	
			☐ Personal	☐ Work Related
Company responsible for today's fees (if personal, write self)				
Name of Billing Contact			Billing Phone Number	
Billing Address				
City	State	Zip Code	Parish/County	
Billing Email		HSE Email		
Name of HSE Contact			HSE Phone Number	

I understand that by signing this form, I authorize XstremMD 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 XstremMD 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.

Printed Name ______________________ Title ______________________

Signature *required for new companies* ______________________ Date ______________________

☐ **Check here if paying by credit card at time of service**