AUTHORIZATION OF PAYMENT

COMPANY INFORMATION

Company Rep/Manager's Name:		
Company Name:		
Company Address:		
Phone:	Fax:	Email:

EMPLOYEE INFORMATION

Employee Name:	
Employee National Id#:	

Indicate your willingness to accept charges for the following ancillary services:

☐ X-ray ☐ MRI

☐ Ultrasound ☐ Lab Work

☐ CT Scan ☐ Take Home Medication

Indicate your willingness to accept charges for follow-up treatment(s)/visit(s) related to this injury/episode by ticking the appropriate box.

☐ Yes ☐ No

I hereby authorize the treatment of the above-named patient, this includes a physical examination and any in-house investigations and treatments deemed fit by the medical physician in order to facilitate the management of the patient. Please note that any reporting will be restricted to the cost of treatment any further medical information required by the employer will ONLY be given on consent of the patient and may incur a cost.

NB: Please be advised that payment is due one month after the date of invoice and must be paid in FULL.

I/WE UNDERSTAND THAT FAIULURE TO PAY AS AGREED WILL LEAD TO IMMEDIATE LEGAL ACTION TO RECOVER THE AMOUNT DUES AND OWING TO FMH EMERGENCY MEDICAL CLINIC, INCLUSIVE OF ALL LEGAL COSTS, ATTORNEYS FEES AND DEBT COLLECTOR EXPENSES.

AUTHORIZED SIGNATURE: _____

DATE: _____/____/____

YYYY MM DD