



Services authorized:

- MRI
- Physical/Occupational Therapy
- EMG/Nerve Conduction
- CT Scan
- Referral to specialist
- Other: _____

This agreement for payment of health services rendered is between Highland Clinic and

_____ (employer name)

whereby the aforementioned client agrees to the following:

1. I agree that I am liable for all payments associated with the injury treatment of my employee, _____
2. I agree that Highland Clinic will provide me with a Health Insurance Claim Form (HCFA) stating charges for which I am responsible and I will make payment for such charges within 60 days of receipt of HCFA.
3. I agree to make appropriate payment to Highland Clinic for services rendered in accordance with the Louisiana Workers' Compensation fee schedule.

Company Name Name (Printed)

Authorized Signature Date