FAMILY CONVENIENCE CLINIC

2933 Cypress Street Ste 1
West Monroe, LA 71291
Phone: 318-322-9252
Fax: 318-322-2885

Company Profile Sheet

Company Information

Legal Business Name: ____________________ ☐ Current W-9 form attached

If Applicable - Doing Business As: ____________________

EIN # _______-__________ Phone Number: __________ Fax Number: __________

Physical Address: ____________________

Mailing Address: ____________________

Person(s) Authorized to act on behalf of the business:

____

____

Are the personnel listed above authorized to approve payments on behalf of the company? ☐Yes ☐No
*If no, please list the person(s) responsible to authorize payments on behalf of the company?

____

****If employee/student/patient is responsible for payment, please specify ☐Yes ☐No**

For Work - Injury Exams Only:

Do you prefer to have your work-comp claim: ☐ invoiced directly to your company ☐ claim filed with your carrier

If claim filed complete the following:

Insurance Carrier Name: __________ Policy No.: __________

Address of Carrier: ____________________

City: __________ State: ______ Zip: ______ Phone Number of Carrier: _____-_____-______ ext # ______

Title & Person Authorizing Claim: ____________________

Services Requested:

Physical Exam :
- Pre-employment ☐
- DOT ☐
- School ☐
- Fitness for Duty ☐
- Daycare ☐
- Facility Admission ☐
- Post-Accident ☐
- Other__________ ☐

____

Labs:

Drug Screen
- Collection Only ☐ Post-Accident ☐
- Pre-Employment ☐ Random-Test ☐
- In-house Screen ☐ Saliva (ETOH) ☐

Titers ☐

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Other:☐ Please list:

____

____

Vaccines:
- Hep B vaccine ☐
- Tdap ☐
- Flu vaccine ☐
- Other__________ ☐

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Other:
- Audiometer Screen ☐
- EKG ☐
- PPD ☐
- Radiology ☐

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OFFICE USE ONLY

Office personal: __________ Date Profile Completed: __________ Approved by: __________ Date: __________