



PROPOSAL FOR SERVICES AUTHORIZATION FORM

Company Name/ Responsible Party	Allied Universal Corp				
Billing Address	3901 NW 115 AVENUE				
City	MIAMI	State	FL	Zip	33178
Phone	305-888-2623	Email	patri@allieduniversal.com		

I hereby authorize and direct the above company that i represent to pay to Xpress Urgent Care such sums as may be due and owing him/her for medical services rendered my company for the administration of medical services per the following terms:

Services	Proposed Fee per Individual Service(s)
Work Physical Exam	\$65
Mask/ Respirator Fit Test	\$65
DOT Physical Exam	\$110
BAT (DOT only)	\$50
Drug Screen, Urine (All Panels- 5/7/9/10/12) and DOT DS	\$50
Covid Testing (PCR)	\$65
Spirometry/Pulmonary Function Test	\$40
Hepatitis B Vaccine (3 series)	\$90
OSHA Questionnaire	\$65

I understand that I will be furnished with a detailed invoice for payment that will itemize the services rendered

I fully understand that such payment is not contingent on any other means by which I may eventually recover said fee

If this account is assigned for collection and/or suit, collection cost and/or interest, and/or attorney's fee, and/or court costs will be added to the total amount of fee. If I disregard my financial responsibility, I understand I will be turned over to a collection agency, which may significantly affect my credit rating and that a 1099-C report will be made to the Internal Revenue Service.

_____	_____	_____
Xpress Representative	Signature	Date

_____	_____	_____
Xpress Representative	Signature	Date