AMERICAN ESOTERIC LABORATORIES
A Sonic Healthcare Clinical Laboratory

XIFIN iNet Client Portal Access Approval

Please emailed completed form to: database@ael.com

Account Name: _____   Account Number:_____

CSA/Rep Name: _____

Phone Number: _____   Fax Number: _____

Address: _____
          Street   City   State   Zip

Portal Administrator: _____
                       First   Last

Email Address: _____

_____
Title of Administrator in the office

Additional Users (list first and last name)

1. _____
First   Last
Email Address:_____
(Circle access option requested)
Client Invoices: No Access   Read Only   Update
Price Inquiry: No Access   Read Only
Docs: No Access   Read Only   Update
Billing Errors: No Access   Update
Quick Pay: No Access   Read Only   Update
User Admin: No Access   Read Only   Update

2. _____
First   Last
Email Address:_____
(Circle access option requested)
Client Invoices: No Access   Read Only   Update
Price Inquiry: No Access   Read Only
Docs: No Access   Read Only   Update
Billing Errors: No Access   Update
Quick Pay: No Access   Read Only   Update
User Admin: No Access   Read Only   Update

I _____ authorize the users listed above to have access to the XIFIN iNet Client Portal for my account.

Authorized by:_____
                First   Last

Signature:_____   Date:_____