Customer Service Agreement

Urgent Care TX – Employer Health Services
1208 W Henderson St. Ste A, Cleburne TX 76033
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SECTION I:	COMPANY INFORMATION		
Today's Date		TPA Name	
Company Name			
Number of Employees		Health Insurance Carrier	
Phone		Fax	
Main Company Address City, State, ZIP Code			

COMPANYINFORMATION			
1. Primary Contact/DER Name		**2. Secondary Contact**	
Title/Role		Title/Role	
Address City, State, ZIP Code		Address City, State, ZIP Code	
Phone		Phone	
Fax		Fax	
Email		Email	

BILLING INFORMATION	
Primary Billing*	
Billing Address City, State, ZIP Code	
Contact Name and Title	
Phone	
Fax	
Email	☐
Workers' Comp Billing ☐ Reportable ☐ Non-Reportable	
Carrier Name	
Billing Address	
Phone	
Fax	
Are workers' comp claims to be billed to carrier or to your company?	☐ Bill Carrier ☐ Bill Primary Billing Address

*Provide alternate billing addresses on page 3

SECTION II: REQUIRED SERVICES AND REPORTING

$50 ☐ 5 Panel In-house Drug Screen non-DOT (80300.5I)
$50 ☐ 10 Panel In-house Drug Screen non-DOT (80300.10I)
$65 ☐ 5 Panel External Lab **DOT** Drug Screen (80300.D)
$65 ☐ 10 Panel External Lab Drug Screen, non-DOT (80300.10L)
$25 ☐ Urine Collection Only, non-DOT & **DOT** (99000.D)
$50 ☐ Tetanus, (Tdap) (90715)
$100 ☐ Breath Alcohol Test DOT (82075.D)
$100 ☐ Breath Alcohol Test, non-DOT (82075.N)
$85 ☐ DOT Physical (99385.D)
$120 ☐ COVID-19 Rapid Nasal Test (87426)

$100 ☐ Intravenous (IV) Hydration Infusion (96360)
$30 ☐ History Review W/O Exam (99385.P0010)
$41 ☐ EKG (93000)
$30 ☐ Pure Tone Audiometry (92552)
$65 ☐ Tetanus,Diptheria (90714)
$50 ☐ Chest X-Ray 2 View (71020)
$15 ☐ Blood Sugar Test (82948)
$85 ☐ Pre-Employment Physical (99385.G)
$175 ☐ COVID-19 Rapid Test and Treatment (87426)
$199 ☐ COVID-19 PCR Nasal Swab Test and Treatment (86769)

$25 ☐ Blood Draw Collection (36415)
$158 ☐ Hep B Vaccine (90746)
$50 ☐ Hepatitus B Titer (86706)
$128 ☐ Hep A Vaccine (90632)
$30 ☐ OSHA Audio Exam (92552.O)
$40 ☐ Flu Vaccine (90656)
$40 ☐ PPD (TB Test) (86580)

ONSITE TRAINING SERVICES

_____ ☐ Heart Healthy
_____ ☐ Nutrition
_____ ☐ Stress Relief
_____ ☐ Diabetes
_____ ☐ Tobacco Cessation
_____ ☐ Weight Control
_____ ☐ Back Care
_____ ☐ Sleep Disorders
_____ ☐ Men and Women's Health
_____ ☐ Biometric Screening/With Lab

EMPLOYEE MUST BRING IN COMPLETED AUTHORIZATION FORM FOR SERVICES TO BE PERFORMED

WORKERS' COMPENSATION	Indicate where the Return to Work Status report is to be sent:
☐ Workers' Compensation Injury Treatment ☐ Recordable or ☐ Non-Recordable	
☐ Post-Accident Drug Screen Required	☐ DOT ☐ Non-DOT (5, 7, 9, or 10 Panel) _____

Please indicate where and how breath alcohol tests and physical results are to be reported:

☐ Email ☐ Fax ☐ Return with Employee ☐ Mail

Please list specific protocol instructions*

*Doctors Care will report results and applicable information as specified above

SECTION III: BILLING AND PAYMENT INFORMATION

OPTION A: ☐ Recurring Payment (requires credit card)

Invoices are mailed on the 2nd business day of the month and are due on the 20th. Payments for accounts can be paid by check or with a credit card on file will be processed after the 20th of each month. Any billing discrepancies must be brought to our attention prior to the 20th so we may make the necessary corrections before processing your credit card payment. Past due accounts will be assessed a late payment fee of 10%. Accounts with past due balances over 120 days old will be terminated and referred to a collection agency for payment.

OPTION B: ☐ Balance Billing (requires approval and credit card* for balance billing)

A monthly invoice of open charges will be sent to you at the billing address on file. Customer agrees to pay the invoice on the 20th of each month. If payment falls more than 60 days in arrears, your account will be inactivated and referred to a collection agency for payment and services must be paid for at the time they are rendered. Past due balances will incur a late payment fee of 15% of the outstanding balance.

*Credit card will not be billed unless payment is not made within 30 days.

I, _____ , authorize Urgent Care TX to charge my account for balance due for payment of my account with Urgent Care TX.

CREDIT CARD INFORMATION	
Type of Card	☐ Visa ☐ MasterCard ☐ Discover ☐ American Express
Cardholder Name*	
Account Number	
Expiration Date	
Billing Zip Code	

*The name MUST match the name on the credit card listed

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Urgent Care TX in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day.

Credit Card Authorization Signature: _____

If you have some services that must be billed to an alternate billing address, please provide that information below:

Name	
Address	
Phone	
Services to be billed to this address	

SECTION V: FEES & NOTES

This section to be completed by business development representative

SECTION VI: CUSTOMER ACKNOWLEDGEMENT

Employer Authorized Name

Title

X

Employer Authorized Signature

Date

This agreement will be in effect until either party gives written notice of change of service, terms or termination.