Employer Services Agreement

Integrity Urgent Care
PO Box 14950 Oklahoma City, OK 73113
Email: occmed@xpwell.com

SECTION I:	CUSTOMER INFORMATION		
Date		TPA Name	
Company Name			
Multiple locations?		If yes, list locations	
Phone		Fax	
Main Company Address City, State, ZIP			
CUSTOMER INFORMATION			
Primary Contact/DER Name		**Secondary Contact**	
Title/Role		Title/Role	
Address City, State, ZIP		Address City, State, ZIP	
Phone		Phone	
Fax		Fax	
Email		Email	
BILLING INFORMATION			
Primary Billing*			
Billing Address City, State, ZIP			
Contact Name and Title			
Phone			
Fax ☐			
Email ☐			
Workers' Comp Billing*			
Carrier Name			
Billing Address: City, State, ZIP			
Contact Name and Title			
Phone			
Fax			
Are workers' comp claims to be billed to carrier or to your company?	☐ Bill Carrier ☐ Bill Primary Billing Address (please provide email to send statements)		
SECTION II:	**REQUIRED SERVICES AND REPORTING**		

DRUG SCREENING

All services may not be available at all locations.

- ☐ Urine Drug Collection (Company COC) $35
- ☐ Observed Fee (no charge)
- ☐ Breath Alcohol Test$45
- ☐ Hair Follicle Collect. ($100 in house; $45 own CCF)
- ☐ 10 Panel Non-DOT $50
- ☐ 5 Panel Non-DOT $50
- ☐ 5 Panel DOT $50
- ☐ 10 Panel In-House $50
- ☐ 5 Panel In-House $50

PHYSICAL EXAM

All services may not be available at all locations.

- ☐ DOT Physical (price varies by location)
- ☐ General Physical $75
- ☐ Pre-Employment Physical $75
- ☐ Lift test $35
- ☐ Bus Driver Physical $75
- ☐ **OTHER** _____

IMMUNIZATIONS

All services may not be available at all locations.

- ☐ Flu Vaccine $40
- ☐ Tetanus $75
- ☐ Hep B Vaccine $120
- ☐ **OTHER**_____
- ☐ **OTHER** _____

LABS

All services may not be available at all locations.

- ☐ Hep A Titer$100
- ☐ Measles $40
- ☐ PPD (TB Test) $45
- ☐ Varicella Titer $136
- ☐ Hep B Titer $ 120
- ☐ Mumps $36
- ☐ PPD/TB Gold/Blood $100
- ☐ **OTHER** _____
- ☐ Hep C Titer $42
- ☐ Rubella $115
- ☐ HIV 1 & 2 $163
- **OTHER** _____

TESTING

All services may not be available at all locations.

- ☐ EKG $40
- ☐ Vision Screen $25 per test
  - ☐ Snellen
  - ☐ Ishihara
  - ☐ Jeager
- **OTHER** ☐ _____
- ☐ Audiogram $40
- ☐ Chest X-ray 1 or 2 view $100
- ☐ Respiratory Fit (Qualitative) $55
- ☐ PFT/Spirometry $90
- ☐ Jamar Grip Test $15
- ☐ OSHA Questionnaire $25

WORKERS' COMPENSATION

All services may not be available at all locations.

☐ Workers' Compensation Injury Treatment

☐ Post-Accident Drug Screen Required

☐ DOT (5 panel) ☐ Non-DOT (10 Panel) _____

☐ Collection Only

Indicate where Return to Work Status report is to be sent:

Please indicate where to bill drug screen (Note: Any drug screen billed to work comp carrier & denied will be the responsibility of employer):

- ☐ Employer
- ☐ Work Comp Carrier

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*	

SECTION III:	BILLING AND PAYMENT INFORMATION

Balance Billing: ** A monthly statement of open charges will be sent to you at the billing address on file. Customer agrees to net 30 terms from the date of each statement. If payment falls more than 60 days in arrears from any statement date, your account may be suspended until fully resolved. If payment falls more than 90 days in arrears from any statement date, Customer's account may be sent to collections for resolution and payment for additional services will be required at the time they are rendered. **

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 at this address	

Please list the Urgent Care clinic/clinics that your company would like to use. If in a particular state please indicate that:

☐OK ☐KS ☐TX

SECTION IV:	OTHER FEES & NOTES (This section to be completed by business development representative)

SECTION V:	CUSTOMER ACKNOWLEDGEMENT

The initial term of this Agreement shall begin on the date it is executed by the Customer and shall expire after one (1) year. This Agreement shall thereafter automatically renew for additional one (1) year terms. This Agreement may be terminated by either party, for any reason or no reason at all, upon ninety (90) days' prior written notice. Pricing is subject to annual increases. Pricing increases will be discussed with and agreed upon by Customer prior to implementing the same.

Customer shall not, without obtaining the prior written consent of Xpress Wellness LLC, disclose any information relating to pricing, marketing materials or any other confidential information of Xpress Wellness Urgent Care, Integrity Urgent Care, Williams Medical Group Practice LLC, DCS Medical PA or any third-beneficiary of this Agreement (collectively, "Confidential Information") except: i) to employees and agents of Customer with a need to know who are required to keep such information confidential; or ii) as required pursuant to a subpoena, order or request issued by a court of competent jurisdiction or by a judicial or governmental order or process.

_____ _____

Customer Authorized Name Title

X_____ _____

Customer Authorized Signature Date