

**XpressWellness****U R G E N T C A R E**

Employer Services Agreement

Xpress Wellness Urgent Care

701 Cedar Lake Blvd, Suite 160, Oklahoma City, OK 73114

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 <input type="checkbox"/>			
Email <input type="checkbox"/>			
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?	<input type="checkbox"/> Bill Carrier <input type="checkbox"/> Bill Primary Billing Address (please provide email to send statements)		
SECTION II: REQUIRED SERVICES AND REPORTING			

DRUG SCREENING

- | | | |
|---|--|---|
| <input type="checkbox"/> Urine Drug Collection \$35 | <input type="checkbox"/> 10 Panel DOT/Non-Federal \$50 | <input type="checkbox"/> 10 Panel In-House \$50 |
| <input type="checkbox"/> Observed Fee (no charge) | <input type="checkbox"/> Breath Alcohol Test \$45 | <input type="checkbox"/> 9 Panel In-House (excludes THC) \$50 |
| | <input type="checkbox"/> Hair Follicle Collection (\$100 in-house; \$50 own CCF) | <input type="checkbox"/> 4 Panel In-House (excludes THC) \$50 |

PHYSICAL EXAM

- | | | |
|--|---|---|
| <input type="checkbox"/> DOT Physical (price varies by location) | <input type="checkbox"/> Pre-Employment Physical \$75 | <input type="checkbox"/> Bus Driver Physical \$75 |
| <input type="checkbox"/> General Physical \$75 | <input type="checkbox"/> Lift test \$35 | <input type="checkbox"/> OTHER _____ |

IMMUNIZATIONS

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> Flu Vaccine \$40 | <input type="checkbox"/> Hep B Vaccine \$120 | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> Tetanus \$75 | | <input type="checkbox"/> OTHER _____ |

LABS

- | | | |
|--|--|---|
| <input type="checkbox"/> Hep A Titer \$100 | <input type="checkbox"/> Hep B Titer \$ 120 | <input type="checkbox"/> Hep C Titer \$42 |
| <input type="checkbox"/> Measles \$40 | <input type="checkbox"/> Mumps \$36 | <input type="checkbox"/> Rubella \$115 |
| <input type="checkbox"/> PPD (TB Test) \$45 | <input type="checkbox"/> PPD/TB Gold/Blood \$100 | <input type="checkbox"/> HIV 1 & 2 \$163 |
| <input type="checkbox"/> Varicella Titer \$136 | <input type="checkbox"/> OTHER _____ | OTHER _____ |

TESTING

- | | | |
|--|---|--|
| <input type="checkbox"/> EKG \$40 | <input type="checkbox"/> Audiogram \$40 | <input type="checkbox"/> Jamar Grip Test \$15 |
| <input type="checkbox"/> Vision Screen \$25 per test | <input type="checkbox"/> Chest X-ray 1 or 2 view \$100 | <input type="checkbox"/> OSHA Questionnaire \$25 |
| <input type="checkbox"/> Snellen | <input type="checkbox"/> Respiratory Fit (Qualitative) \$55 | |
| <input type="checkbox"/> Ishihara | <input type="checkbox"/> PFT/Spirometry \$90 | |
| <input type="checkbox"/> Jeager | | |

OTHER ☐ _____

WORKERS' COMPENSATION

- | | |
|---|--|
| <input type="checkbox"/> Workers' Compensation Injury Treatment | Indicate where Return to Work Status report is to be sent: |
| <input type="checkbox"/> Post-Accident Drug Screen Required | Please indicate where to bill drug screen (Note: Any drug screen billed to work comp carrier & denied will be the responsibility of employer): |
| <input type="checkbox"/> DOT <input type="checkbox"/> Non-DOT (10 Panel) _____
<input type="checkbox"/> Non-DOT (12 Panel) _____
<input type="checkbox"/> Collection Only | <input type="checkbox"/> Employer
<input type="checkbox"/> Work Comp Carrier |

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

- | | | | |
|--------------------------------|------------------------------|---|-------------------------------|
| <input type="checkbox"/> Email | <input type="checkbox"/> Fax | <input type="checkbox"/> Return with Employee | <input type="checkbox"/> 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 Xpress Wellness 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