Doctors Care - Employer Health Services

Submit by Email

Customer Service Agreement

1600 Hwy 17 N, Surfside Beach, SC 29575
Phone: 843-238-4520
Email: Sales@DoctorsCare.com

SECTION I: CUSTOMER INFORMATION & ACCOUNT SETUP

Today's Date							
Company Name							
Company Website							
Number of Employees							
Types of Services Offered							
WC Carrier Information							
1. Primary Contact/DER							
Title/Role							
Address		City		State		Zip Code	
Phone		Fax					
Email							
3. Secondary Contact							
Title/Role							
Address		City		State		Zip Code	
Phone		Fax					
Email							
2. Billing Contact							
Title/Role							
Address		City		State		Zip Code	
Phone		Fax					
Email							
Email Invoices? (secured)	☐ Yes ☐ No						

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SECTION II: REQUIRED SERVICES (check all that apply)

Work Related

- ☐ Worker's Compensation Injury Treatment
- ☐ Post-accident Drug Screen required

Drug Screen/Breath Alcohol Testing

- ☐ Drug Screen:
  - ☐ DOT
  - ☐ Non-DOT: ☐ 5 Panel ☐ 9 Panel ☐ 10 Panel ☐ 7 Panel ☐ Other _____
  - ☐ Instant
  - ☐ Collection only
- ☐ Breath Alcohol:
  - ☐ DOT
  - ☐ Non-DOT
- ☐ Random Drug Screen pulls for regulatory requirements.

Physical Examination

- ☐ DOT Physical
- ☐ Pre-Employment PE
- ☐ Respiratory Clearance PE
- ☐ Physical (Other):

Specify: _____

Special Examination

- ☐ Audiogram
- ☐ Blood Lead Level
- ☐ Chest X-ray
- ☐ Hepatitis B Immunization
- ☐ Hepatitis B Titer
- ☐ Spirometry with Letter
- ☐ PPD (TB test)
- ☐ Tetanus
- ☐ Flu Shot
- ☐ Other: _____
- ☐ Other: _____

SECTION III: INSTRUCTIONS TO US - RESULTS AND PROTOCOL

Please be sure to denote who the designated employee representative (DER) at your organization will be for receiving the results (above).

Please specify how the drug screen results are to be reported:

- ☐ Fax
- ☐ Email
- ☐ Mail

Please specify how all other results are to be reported:

- ☐ Fax
- ☐ Email
- ☐ Mail
- ☐ Returned with Employee

Additional Comments: _____

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SECTION IV: BILLING AND PAYMENT INFORMATION

OPTION A: ☐ **Recurring Payment** *(RECOMMENDED)*

Pay via Visa, MasterCard, or Discover Card with receipt emailed to the billing contact on file.

I, _____, authorize Doctors Care (c/o UCI Medical Affiliates) to charge my account for balance due for payment of my account with Doctors Care.

CREDIT CARD INFORMATION	
Type of Card	☐ VISA ☐ MC ☐ DISCOVER
Cardholder Name	
Account Number	
Expiration Date	
CVV Number	

*CVV Number is a 3 or 4 digit number on the back of your card.
**The name below 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 UCI Medical Affiliates 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: _____

OPTION B: ☐ **Balance Billing**

Your company must commit to spending a minimal of $1,000.00 annually to qualify for direct billing. A monthly invoice of open charges will be sent to you at the Billing address on file. Customer agrees to pay the invoice within 30 days of the invoice date. If payment falls more than 60 days in arrears, the account is inactivated and services must be paid for at the time they are rendered.

Please list the Doctors Care Facility that your company would like to utilize:

_____
_____
_____
_____
_____
_____

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SECTION V: CUSTOMER ACKNOWLEDGEMENT

We look forward to serving you and your employees' health needs.

CUSTOMER:

e-Signature: _____ Date: _____

DOCTORS CARE:

e-Signature: _____ Date: _____

Doctors Care HIPAA & Patient Privacy Notices:
http://www.doctorscare.com/patients/hipaa_policy/

Doctors Care Employer Authorization Form:
http://doctorscare.com/public/files/docs/DoctorsCareEmployerAuthorizationForm.pdf

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

Note: Doctors Care policy is to have a completed authorization form accompanying employee at time of service.

Disclaimer: By my using the e-signature feature of this online application, I represent without reservation that I have the legal authority to submit this information on behalf of myself (or on behalf of the company/affiliation on whose behalf I am acting). I agree that my use of the e-signature constitutes an "electronic signature" as defined by the Electronic Signatures in Global and National Commerce Act ("E-Sign") and the Uniform Electronic Transactions Act ("UETA").

Submit by Email

For Internal Use Only

Account #	
EHS Representative	
Phone	
Fax	
Email	

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SECTION VI: Customer Pricing Agreement

For Internal Use Only

Work Related

- ☐ Worker's Compensation Injury Treatment ..... Price: _____
- ☐ Post-accident Drug Screen required ..... Price: _____

Drug Screen/Breath Alcohol Testing

- ☐ Drug Screen:
  - ☐ DOT ..... Price: _____
  - ☐ Non-DOT:
    - ☐ 5 Panel ..... Price: _____
    - ☐ 7 Panel ..... Price: _____
    - ☐ 9 Panel ..... Price: _____
    - ☐ 10 Panel ..... Price: _____
    - ☐ Other _____ ..... Price: _____
  - ☐ Instant ..... Price: _____
- ☐ Breath Alcohol:
  - ☐ DOT ..... Price: _____
  - ☐ Non-DOT ..... Price: _____
- ☐ Random Drug Screen Services ..... Price: _____

Physical Examination

- ☐ DOT Physical ..... Price: _____
- ☐ Pre-Employment PE ..... Price: _____
- ☐ Respiratory Clearance PE ..... Price: _____
- ☐ Physical (Other): ..... Price: _____

Specify: _____

Special Examination

- ☐ Audiogram ..... Price: _____
- ☐ Chest X-ray ..... Price: _____
- ☐ Hepatitis B Titer ..... Price: _____
- ☐ PPD (TB test) ..... Price: _____
- ☐ Flu Shot ..... Price: _____
- ☐ Other: _____ ..... Price: _____
- ☐ Other: _____ ..... Price: _____
- ☐ Blood Lead Level ..... Price: _____
- ☐ Hepatitis B Immunization ..... Price: _____
- ☐ Spirometry with Letter ..... Price: _____
- ☐ Tetanus ..... Price: _____