

New Account Setup

Novant Health Urgent Care – Employer Health Services
1818 Henderson Street | Columbia, SC 29201
Phone: 843.238.4520 | Email: sales@doctorscare.com

Today's Date

Client Rep

COMPANY INFORMATION

| | | | |
|--------------------------|---------------------|---------------------|-----|
| Company Name | | Number of Employees | |
| Physical Company Address | City | State | Zip |
| Contact Name | Phone | Phone | |
| Contact Email Address | Additional Contacts | | |

BILLING DETAILS FOR OCCUPATIONAL SERVICES

| | | | |
|--|---------------------|-------------------|-----|
| Billing Address is: <input type="checkbox"/> Same as physical address <input type="checkbox"/> Different from physical address | | | |
| Billing Address | City | State | Zip |
| Billing Contact Name | TPA (if applicable) | | |
| Billing Contact Email | TPA Contact Name | TPA Contact Phone | |

BILLING DETAILS FOR WORKERS' COMPENSATION

| | | | |
|--|------|-------|-----|
| Workers' Comp Insurance Name | | | |
| Address / PO Box | City | State | Zip |
| <input type="checkbox"/> Self-insured Billing Address (if different than physical address) | | | |
| Billing Address | City | State | Zip |

BILLING AND PAYMENT OPTIONS

- OPTION A:** ☐ **Pay via Visa, MasterCard, Discover Card or American Express with receipt emailed to the billing contact on file.** Invoices are mailed by the 10th day of the month and are due 30 days net receipt. Payments for accounts with a credit card on file will be processed after the 20th of each month. Any billing discrepancies must be brought to our attention within 5 days after receipt so we may make the necessary corrections before processing your credit card payment. Accounts with past due balances over 60 days old will be terminated and referred to a collection agency for payment. If accounts are terminated the employer will only be able to send employees for services offered to self-pay patients.
- OPTION B:** ☐ **A monthly invoice of open charges will be sent to you at the billing address on file.** Customer agrees to pay the invoice on 30 days after receipt. Credit card will not be billed unless payment is not made within 30 days. 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. If accounts are terminated the employer will only be able to send employees for services offered to self-pay patients.

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| CREDIT CARD INFORMATION | | |
|-------------------------|---|------------------|
| Cardholder Name | Type of Credit Card: <input type="checkbox"/> VISA <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover <input type="checkbox"/> American Express | |
| Account Number | Expiration Date | Billing ZIP Code |

I, _____ (print name) authorize Novant Health Urgent Cares, LLC to charge my account for balance due for payment of my account with Novant Health Urgent Cares, LLC.

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Novant Health Urgent Cares, LLC 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: _____

All accounts may pay online by echeck by visiting <https://employers.doctorscare.com/pay>

You will receive any updates in pricing annually. Changes will be provided 60 days prior to going into effect.

CUSTOMER ACKNOWLEDGEMENT OF AUTHORIZED SERVICES AND TERMS

This agreement shall be effective on the date of both parties sign the agreement and continue for a period of 2 years (Initial Term). After the expiration of the Initial Term, the agreement will renew for successive 2 year terms.

| | |
|---|--|
| Customer Authorized Representative Name | Customer Authorized Representative Title |
| Signature | Date Signed |

| | |
|--|---|
| Novant Health Authorized Representative Name | Novant Health Authorized Representative Title |
| Signature | Date Signed |

SUBMITTING THE COMPLETED DOCUMENT

Please submit the completed document, including the authorized services and specific instructions section to:

Novant Health Urgent Care – Employer Health Services

1818 Henderson Street

Columbia, SC 29201

Phone: 843.238.4520 | Email: sales@doctorscare.com

| | |
|-------------------|---------------------|
| | FOR OFFICE USE ONLY |
| NHUC staff member | Receipt Date |

AUTHORIZED SERVICES

Please select only the services you (Employer) will be financially responsible for. If a Third Party Administrator (TPA) is being used, they must complete a separate billing agreement and specify the services they will cover.

Pre-Employment Drug Screen

- ☐ DOT Panel
- ☐ 4-Panel Non DOT
- ☐ 5-Panel Non DOT
- ☐ 6-Panel Non DOT
- ☐ 7-Panel Non DOT
- ☐ 8-Panel Non DOT
- ☐ 9-Panel Non DOT
- ☐ 10-Panel Non DOT
- ☐ 11-Panel Non DOT
- ☐ Collection Only
- ☐ Breath Alcohol
- ☐ Breath Alcohol Confirmation

Post-Accident Drug Screens

- ☐ DOT Panel
- ☐ 4-Panel Non DOT
- ☐ 5-Panel Non DOT
- ☐ 6-Panel Non DOT
- ☐ 7-Panel Non DOT
- ☐ 8-Panel Non DOT
- ☐ 9-Panel Non DOT
- ☐ 10-Panel Non DOT
- ☐ 11-Panel Non DOT
- ☐ Collection Only
- ☐ Breath Alcohol
- ☐ Breath Alcohol Confirmation

Random/For Cause Drug Screens

- ☐ DOT Panel
- ☐ 4-Panel Non DOT
- ☐ 5-Panel Non DOT
- ☐ 6-Panel Non DOT
- ☐ 7-Panel Non DOT
- ☐ 8-Panel Non DOT
- ☐ 9-Panel Non DOT
- ☐ 10-Panel Non DOT
- ☐ 11-Panel Non DOT
- ☐ Collection Only
- ☐ Breath Alcohol
- ☐ Breath Alcohol Confirmation

Physicals

- ☐ Pre-Employment
- ☐ Occ Health Physical
- ☐ DOT Physical
- ☐ Fire Fighter Physical
- ☐ Police Physical
- ☐ Dive Physical
- ☐ Hazardous Material Physical
- ☐ Respirator Physical
- ☐ Respirator Physical w/ Questionnaire
- ☐ Respirator Questionnaire (pass/fail only)

Ancillary Services

- ☐ Respirator Fit Test (Qualitative)
- ☐ Audio Screening (Pure Tone)
- ☐ Audio Function (OSHA Booth)
- ☐ Visual Acuity Screen
- ☐ Ishihara Color Test
- ☐ Electrocardiogram (EKG)
- ☐ BMI (Height, Weight, Blood Pressure)
- ☐ Spirometry (PFT)

In-House Lab Tests

- ☐ Urinalysis
- ☐ Glucose
- ☐ Hemoglobin A1c
- ☐ HCG (pregnancy)
- ☐ Fecal Occult Blood

Radiology Services

- ☐ Chest x-ray 2 view
- ☐ LS Spine x-ray 2 view

Send-out Labs

- ☐ Basic Metabolic Panel
- ☐ Complete CBC
- ☐ Comprehensive Metabolic Panel
- ☐ Hepatitis B Exposure
- ☐ HIV
- ☐ Lead
- ☐ Lipid Panel
- ☐ Prostate Specific Antigen
- ☐ Other: _____
(only includes labs on our current service offerings)

Blood Draws

- ☐ TB/PPD Test
- ☐ QuantiFERON – TB (Q-Gold)
- ☐ MMR Titer
- ☐ Rubella Titer
- ☐ Mumps Titer
- ☐ Varicella Titer
- ☐ Hepatitis A Titer
- ☐ Hepatitis B Titer
- ☐ Hepatitis C Titer

Vaccines

- ☐ Flu
- ☐ Hepatitis B (2 doses required)
- ☐ TDAP

* Service availability may vary by location. Check with your account team to confirm offerings.

RESULTS REPORTING

| MAIN CONTACT | SECONDARY CONTACT | OTHER CONTACT |
|--|--|---|
| Main Contact Name | Secondary Contact Name | Other Contact Name |
| Phone | Phone | Phone |
| FAX | FAX | FAX |
| Email | Email | Email |
| <input type="checkbox"/> To receive all results/reports <input type="checkbox"/> to receive only <input type="checkbox"/> Occ Med results/reports <input type="checkbox"/> Work Comp results/reports | <input type="checkbox"/> To receive all results/reports <input type="checkbox"/> to receive only <input type="checkbox"/> Occ Med results/reports <input type="checkbox"/> Work Comp results/reports | <input type="checkbox"/> To receive all results/reports <input type="checkbox"/> to receive only <input type="checkbox"/> Occ Med results/reports <input type="checkbox"/> Work Comp results/reports |
| List services to be sent to main contact if not receiving all results/reports: | List services to be sent to secondary contact if not receiving all results/reports: | List services to be sent to other contact if not receiving all results/reports: |
| <input type="checkbox"/> Results for DS & BAT only are viewed online in myeScreen portal. <input type="checkbox"/> Results for DS & BAT only are: <input type="checkbox"/> Emailed <input type="checkbox"/> Faxed | <input type="checkbox"/> Results for DS & BAT only are viewed online in myeScreen portal. <i>(Note: Only main contact may add additional users to myeScreen program)</i> <input type="checkbox"/> Results for DS & BAT only are: <input type="checkbox"/> Emailed <input type="checkbox"/> Faxed | <input type="checkbox"/> Results for DS & BAT only are viewed online in myeScreen portal. <i>(Note: Only main contact may add additional users to myeScreen program.)</i> <input type="checkbox"/> Results for DS & BAT only are: <input type="checkbox"/> Emailed <input type="checkbox"/> Faxed |

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SPECIFIC INSTRUCTIONS

What should our team know/do at the beginning of the visit?

OCC MED

- ☐ Authorization is required prior to treatment. If this box is not checked we will treat all employees who come for services and can demonstrate they are employed by your company.

WORKER'S COMP

- ☐ Authorization is required prior to treatment
- ☐ Post-Accident testing required

What should our team know/do during the visit?

OCC MED

WORKER'S COMP

- ☐ Modified duty available

What should our team know/do at the end of the visit?

OCC MED

WORKER'S COMP