Customer Service Agreement

Fast Pace Health – Employer Health Services

6550 Carothers Parkway, Suite 225 Franklin, TN 37067

Email: ohs.billing@Fast Pacehealth.com

SECTION I:	CUSTOMER INFORMATION		
Date		TPA Name	
Company Name	Name of Staffing Agency (if used)		
Number of Employees		Health Insurance Carrier	
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		
SECTION II:	**REQUIRED SERVICES AND REPORTING**		

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DRUG SCREENING

- ☐ Urine Collection Only (80306UC) $29
- ☐ Federal / DOT (80306) $65
- ☐ 10 Panel eScreen Instant (eCup+)(80306) $65
- ☐ Observed Fee (99211OF) $20
- ☐ Breath Alcohol Test (82075) $50
- ☐ 10 Panel Lab (80306) $65
- ☐ TN Drug Free (80306) $65

PHYSICAL EXAM

- ☐ Pre-Employment (99455ND) $109
- ☐ Fit For Duty (97161) $99
- **OTHER**_____
- ☐ DOT Physical (99455) $109
- ☐ Lift test (97161L) $99
- **OTHER**_____

IMMUNIZATIONS

- ☐ Flu Vaccine (90686) Pricing TBD
- ☐ Hep B Vaccine (90746) $125
- ☐ Tetanus, Diphtheria (90714) $42
- ☐ Tetanus, (Tdap) (90715) $75
- ☐ Immunization Administration (90471) $25
- **OTHER** _____

LABS

- ☐ Hep A Titer (86708) $15
- ☐ Hep B Titer (86317)$15
- ☐ Hep C Titer (86803) $15
- ☐ Hepatitis Panel 4 (80074) $85
- ☐ Venipuncture (36415) $25
- ☐ MMR Titer (86735, 86765, 86762) $100
- ☐ PPD (TB Test) (86580) $25
- ☐ PPD/TB Gold/Blood (86480) $100
- ☐ PPD Questionnaire (86580Q) $15
- ☐ Varicella Titer (86787) $70
- **OTHER** _____
- **OTHER** _____

TESTING

- ☐ EKG (93000) $60
- ☐ Pure Tone Audiometry (92551) $15
- ☐ Color Vision Exam (92283BCS) $40
- ☐ Visual Acuity Test – Snellen (99173) $20
- ☐ Chest X-ray 1 or 2 view (71046) $100
- **OTHER** _____

TELEMEDICINE / ONSITE SERVICES / BEHAVIORAL HEALTH

- ☐ Telemedicine
- ☐ Onsite / Near Site
- ☐ Behavioral Health

OTHER _____

WORKERS' COMPENSATION

☐ Workers' Compensation Injury Treatment

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

☐ Post-Accident DrugScreen Required (If so please select from one below)

- ☐ Federal / DOT
- ☐ 10 Panel eScreen Instant (eCup+)
- ☐ Collection Only
- ☐ TN Drug Free

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*	

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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 Fast Pace Health facility/facilities that your company would like to use. If in a particular state please indicate that:

☐TN ☐KY ☐IN ☐LA ☐MS ☐AL

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.

Services provided under this agreement may be rendered by affiliates of FPMCM, LLC doing business under the trade names Fast Pace Health, Christian Family Medicine, Reelfoot Family Walk-in Clinic, Calcasieu or First Care; each such entity shall bill Customer for its services in accordance with this Agreement and shall be a third-party beneficiary of this Agreement.

Customer shall not, without obtaining the prior written consent of FPMCM, LLC, disclose any information relating to pricing, marketing materials or any other confidential information of Fast Pace Health 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