Doctors Place
Walk-in Clinic

Customer Service Agreement

Doctors Place – Employer Health Services
75Summit Ave| Suite 200| Hackensack, NJ
07601 Email: occmed@doctors-place.com

SECTION I:	COMPANY INFORMATION		
Date		TPA Name	
Company Name			
Number of Employees		Health Insurance Carrier	
Phone		Fax	
Main Company Address City, State, ZIP			
COMPANY 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		☐ Fax Invoices	
Email		☐ Email Invoices (Secure)	
Workers' Comp Billing*			
Carrier Name			
Billing Address City, State, ZIP			
Contact Name and Title			

WORKERS' COMPENSATION	
☐ Workers' Compensation Injury Treatment	Indicate where Return to Work Status report is to be sent:
☐ 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):
☐ DOT ☐ Non-DOT (5,7,9 or 10 Panel) _____	☐ Employer ☐ Work comp carrier

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

☐ Email ☐ Fax ☐ Return with Employee ☐ Portal

Please list specific protocol instructions*	

SECTION III: BILLING AND PAYMENT INFORMATION

OPTION A: ☐	**Recurring Payment (requires credit card)** Pay via VISA, MasterCard, Discover Card or American Express with receipt emailed to the billing contact on file. Invoices are mailed on the 5th business day of the month. Any billing discrepancies must be brought to our attention prior to the 2oth so we can make the necessary corrections before processing your credit card payment. Past due accounts will be assessed a late payment fee of 15%. Accounts with past due balances over 90 days old will be terminated until resolved in full. All accounts over 120 days may be sent to collections for resolution.
OPTION B: ☐	**Balance Billing (requires approval and credit card* for balance billing)** A monthly invoice of open charges will be sent to you at the billing address on file. Customer agrees to pay the invoice on the 20thof each month. If payment falls more than 90 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. Past due accounts will incur a late payment fee of 15% of the outstanding balance. Accounts with past due balances over 90 days old will be terminated until resolved in full. All accounts over 120 days may be sent to collections for resolution.

I, _____ Authorize Doctors Place, INC to charge my account for the balance due for payment of my account with Doctors Place, INC

CREDIT CARD INFORMATION

Type of Card	☐ Visa ☐ MasterCard ☐ Discover ☐ American Express
Cardholder Name [must match name on the card listed]	
Account Number	
Expiration Date	
Billing Zip Code	
3-digit security code	

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Doctors Place, INC n 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 noted payment dates fall on a weekend or holiday, I understand that payments may be executed on the next business day.

Credit Card Authorization Signature:_____

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All accounts may be paid online via e-check by visiting https://www.doctors-place.com	
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 Doctors Place, INC facility/facilities that your company would like to use:		

SECTION IV: OTHER FEES & NOTES

This section to be completed by business development representative

SECTION V: CUSTOMER ACKNOWLEDGEMENT

_____ _____

Employer Authorized Name Title

X_____ _____

Employer Authorized Signature Date

This agreement will remain in effect until either party gives written notice of change of service, terms, or termination. Agreement subject to annual increases.20% reduced price is only valid for up to 60 days from signing this contract. Increases will be discussed and agreed upon by all parties prior to implementing.

V1 January 2024