

AGENDA PLACEMENT FORM

(Submission Deadline – Monday, 5:00 PM before Regular Court Meetings)

Date: May 3, 2024

Meeting Date: May 13, 2024

Submitted By: Randy Gillespie

Department: Personnel

Signature of Elected Official/Department Head:

Randy Gillespie

Court Decision: <small>This section to be completed by County Judge's Office</small>

May 13, 2024

Description:

Consideration to approve Employer Services Agreement with Integrity Urgent Care for the purpose of performing drug testing services.

(May attach additional sheets if necessary)

Person to Present: Randy Gillespie

(Presenter must be present for the item unless the item is on the Consent Agenda)

Supporting Documentation: (check one) PUBLIC CONFIDENTIAL
(PUBLIC documentation may be made available to the public prior to the Meeting)

Estimated Length of Presentation: 5 minutes

Session Requested: (check one)
 Action Item Consent Workshop Executive Other _____

Check All Departments That Have Been Notified:
 County Attorney IT Purchasing Auditor
 Personnel Public Works Facilities Management

Other Department/Official (list) _____

**Please List All External Persons Who Need a Copy of Signed Documents
In Your Submission Email**



Employer Services Agreement

Integrity Urgent Care
 PO Box 14950 Oklahoma City, OK 73113
 Email: occmed@xpswell.com

SECTION I: CUSTOMER INFORMATION			
Date	5/13/2024	TPA Name	
Company Name	Johnson County		
Multiple locations?	Yes	If yes, list locations	Multiple throughout County
Phone	817 556-6350	Fax	817 556-6899
Main Company Address City, State, ZIP	2 N. Main St. Rm. 215, Cleburne TX 76033		
CUSTOMER INFORMATION			
Primary Contact/DER Name	Randy Gillespie	Secondary Contact	Chris Brooks
Title/Role	H R Director	Title/Role	Work Comp/Safety Coordinator
Address City, State, ZIP	Same as above	Address City, State, ZIP	Same as above
Phone	817 556-6350	Phone	817 556-6350
Fax	817 556-6899	Fax	817 556-6899
Email	randyg@johnsoncountytexas.org	Email	cbrooks@johnsoncountytexas.org
BILLING INFORMATION			
Primary Billing*			
Billing Address City, State, ZIP	2 N Main St. Rm.215, Cleburne TX 76033 (Billing for Drug Testing)		
Contact Name and Title	Lacy Bruton/Personnel Clerk		
Phone	817 556-6350		
Fax <input type="checkbox"/>	817 556-6899		
Email <input type="checkbox"/>	lbruton@johnsoncountytexas.org		
Workers' Comp Billing*			
Carrier Name	TX Assoc. of Counties RMP/Sedgwick		
Billing Address: City, State, ZIP	P O Box 160120, Austin TX 78716		
Contact Name and Title	Carole Blanchard/WC Claims Asst. carole.blanchard@sedgwick.com		
Phone	512 427-2414		
Fax	859 264-4061		
Are workers' comp claims to be billed to carrier or to your company?	<input checked="" 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

**All services may not be available at all locations.*

- | | | |
|---|---|--|
| <input type="checkbox"/> Urine Drug Collection (Company COC) \$35 | <input type="checkbox"/> 10 Panel Non-DOT \$50 | <input checked="" type="checkbox"/> 10 Panel In-House \$50 |
| <input checked="" type="checkbox"/> Observed Fee (no charge) DOT | <input type="checkbox"/> 5 Panel Non-DOT \$50 | <input type="checkbox"/> 5 Panel In-House \$50 |
| <input checked="" type="checkbox"/> Breath Alcohol Test \$45 | <input checked="" type="checkbox"/> 10 Panel DOT \$50 | |
| <input type="checkbox"/> Hair Follicle Collect.
(\$100 in house; \$45 own CCF) | | |

PHYSICAL EXAM

**All services may not be available at all locations.*

- | | | |
|--|---|---|
| <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

**All services may not be available at all locations.*

- | | | |
|---|--|--------------------------------------|
| <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

**All services may not be available at all locations.*

- | | | |
|--|--|---|
| <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

**All services may not be available at all locations.*

- | | | |
|--|---|--|
| <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"/> Jaeger | | |
| OTHER <input type="checkbox"/> _____ | | |

WORKERS' COMPENSATION

**All services may not be available at all locations.*

- | | |
|---|--|
| <input checked="" type="checkbox"/> Workers' Compensation Injury Treatment | Indicate where Return to Work Status report is to be sent: Both Employer and WC Carrier |
| <input checked="" type="checkbox"/> Post-Accident Drug Screen Required (Motor Vehicle Accidents Only) | |
| <input type="checkbox"/> DOT (5 panel) <input type="checkbox"/> Non-DOT (10 Panel) _____ | 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"/> Collection Only | <input checked="" type="checkbox"/> Employer |
| | <input type="checkbox"/> 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*



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 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.~~

Larry Woolley

Customer Authorized Name

x

Larry Woolley
Customer Authorized Signature

Comm. Pct. 4, Judge Pro Tem

Title

May 13, 2024

Date

x

Mary Winebarger

Integrity Representative

04/29/2024

Date