AGENDA ITEM
CA33

AGENDA PLACEMENT FORM

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

Date: March 17, 2025

Meeting Date: March 24, 2025

Submitted By: Randy Gillespie

Department: Personnel

Signature of Elected Official/Department Head:

Randy Gillespie

Court Decision:
This section to be completed by County Judge's Office

3-24-2025

Description:

Consideration to approve Customer Service Agreement with Urgent Care TX and authorization for Randy Gillespie/Personnel Director to sign.

(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: _____ 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

Customer Service Agreement

Urgent Care TX – Employer Health Services
1208 W Henderson St. Suite A| Cleburne, TX 76033
Phone: 682.317.1500 | Fax: 682-317-1553 | Email: jayline@urgentcaretx.com

SECTION I:	COMPANY INFORMATION		
Today's Date	3/17/2025	TPA Name	
Company Name	Johnson County		
Number of Employees		Health Insurance Carrier	
Phone	(817) 556-6350	Fax	(817) 556-6899
Main Company Address City, State, ZIP Code	2 N. Main St. Rm. 215, Cleburne TX 76033		

COMPANYINFORMATION			
1. Primary Contact/DER Name	Randy Gillespie	**2. Secondary Contact**	Chris Brooks
Title/Role	HR Director	Title/Role	Safety Coordinator / Work Comp
Address City, State, ZIP Code	Same as above	Address City, State, ZIP Code	Same as above
Phone	817-556-6350	Phone	817-556-6350 ext. 1654
Fax	817-556-6899	Fax	
Email	randyg@johnsoncountytx.org	Email	cbrooks@johnsoncountytx.org

BILLING INFORMATION	
Primary Billing*	
Billing Address City, State, ZIP Code	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	817-556-6899
Email	lbruton@johnsoncountytx.org ☐
Workers' Comp Billing ☐ Reportable ☐ Non-Reportable	
Carrier Name	
Billing Address	
Phone	
Fax	
Are workers' comp claims to be billed to carrier or to your company?	☐ Bill Carrier ☐ Bill Primary Billing Address

*Provide alternate billing addresses on page 3

SECTION II: REQUIRED SERVICES AND REPORTING

$60 ☐ 5 Panel In-house Drug Screen non-DOT (80300.5I)
$60 ☒ 10 Panel In-house Drug Screen non-DOT (80300.10I)
$75 ☒ 5 Panel External Lab DOT Drug Screen (80300.D)
$70 ☐ 10 Panel External Lab Drug Screen, non-DOT (80300.10L)
$30 ☐ Urine Collection Only, non-DOT & DOT (99000.D)
$30 ☐ Respiratory Questionnaire
$60 ☒ Saliva Alcohol Screen DOT
$65 ☒ Saliva Alcohol Screen, non-DOT
$95 ☐ DOT Physical (99385.D)
$99 ☐ COVID-19 Rapid Nasal Test (87426)
$199 ☐ COVID-19 Rapid Test and Treatment (87426)

$100 ☐ Intravenous (IV) Hydration Infusion (96360)
$30 ☐ History Review W/O Exam (99385.P0010)
$60 ☐ EKG (93000)
$60 ☐ OSHA Audio Exam (92552.O)
$75 ☐ Tetanus,Diptheria (90714)
$60 ☐ Tetanus, (Tdap) (90715)
$30 ☐ Blood Sugar Test (82948)
$60 ☐ Chest X-Ray 2 View (71020)
$95 ☐ Pre-Employment Physical (99385.G)
$75 ☐ Full Spine X-ray 3 View (72082)

$30 ☐ Blood Draw Collection (36415)
$168 ☐ Hep B Vaccine (90746)
$85 ☐ Hepatitus B Titer (86706)
$138 ☐ Hep A Vaccine (90632)
$50 ☐ Flu Vaccine (90656)
$50 ☐ PPD (TB Test) (86580)

ONSITE TRAINING SERVICES

____ ☐ Heart Healthy
____ ☐ Nutrition
____ ☐ Stress Relief
____ ☐ Diabetes
____ ☐ Tobacco Cessation
____ ☐ Weight Control
____ ☐ Back Care
____ ☐ Sleep Disorders
____ ☐ Men and Women's Health
____ ☐ Biometric Screening/With Lab

EMPLOYEE MUST BRING IN COMPLETED AUTHORIZATION FORM FOR SERVICES TO BE PERFORMED

WORKERS' COMPENSATION	Indicate where the Return to Work Status report is to be sent:
☐ Workers' Compensation Injury Treatment ☐ Recordable or ☐ Non-Recordable	
☐ Post-Accident Drug Screen Required	☐ DOT ☐ Non-DOT (5, 7, 9, or 10 Panel) _____

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*

*Doctors Care will report results and applicable information as specified above

SECTION III: BILLING AND PAYMENT INFORMATION

OPTION A: ☐ Recurring Payment (requires credit card)

Invoices are mailed on the 2nd business day of the month and are due on the 20th. Payments for accounts can be paid by check or with a credit card on file will be processed after the 20th of each month. Any billing discrepancies must be brought to our attention prior to the 20th so we may make the necessary corrections before processing your credit card payment. Past due accounts will be assessed a late payment fee of 10%. Accounts with past due balances over 120 days old will be terminated and referred to a collection agency for payment.

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 20th of each month. 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. Past due balances will incur a late payment fee of 15% of the outstanding balance.

*Credit card will not be billed unless payment is not made within 30 days.

I, _____, authorize Urgent Care TX to charge my account for balance due for payment of my account with Urgent Care TX.

CREDIT CARD INFORMATION	
Type of Card	☐ Visa ☐ MasterCard ☐ Discover ☐ American Express
Cardholder Name*	
Account Number	
Expiration Date	
Billing Zip Code	

*The name 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 Urgent Care TX 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: _____

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 to this address	

SECTION V: FEES & NOTES

This section to be completed by business development representative

SECTION VI: CUSTOMER ACKNOWLEDGEMENT

Randy Gillespie
Employer Authorized Name

Personnel Director
Title

X
Employer Authorized Signature

March 24, 2025
Date

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

Employer Authorization Form

☐ Benbrook ☐ Cleburne ☐ Lancaster

Phone: 682.317.1500 | Fax: 682-317-1553 | Email: jayline@urgentcaretx.com

Complete this form (all fields) and present at time of service

Date: _____ Patient Name: _____ DOB: _____

Employer: _____ Phone: _____ Fax: _____

Employer Address: _____ Gender: M or F

Primary Contact: _____ Email: _____

☐ ***Bill Employer Direct*** ☐ ***Bill Work Comp Insurance*** ☐ ***Bill Patient Directly***

REQUIRED SERVICES (check all that apply) ****** Employee must bring this completed form for services to be rendered******

$65 ☐ 5 Panel In-house Drug Screen non-DOT (80300.5I)

$60 ☐ 10 Panel In-house Drug Screen non-DOT (80300.10I)

$65 ☐ 5 Panel External Lab DOT Drug Screen (80300.D)

$60 ☐ 10 Panel External Lab Drug Screen, non-DOT (80300.10L)

$30 ☐ Urine Collection Only, non-DOT & DOT (99000.D)

$30 ☐ Respiratory Questionnaire

$60 ☐ Saliva Alcohol Screen, non-DOT

$65 ☐ Saliva Alcohol Screen, DOT

$95 ☐ DOT Physical (99385.D)

$99 ☐ COVID-19 Rapid Nasal Test (87426)

$100 ☐ Intravenous (IV) Hydration Infusion (96360)

$30 ☐ History Review W/O Exam (99385.P0010)

$60 ☐ EKG (93000)

$60 ☐ OSHA Audio Exam (92552.O)

$75 ☐ Tetanus, Diptheria (90714)

$60 ☐ Tetanus, (Tdap) (90715)

$60 ☐ Chest X-Ray 2 View (71020)

$95 ☐ Pre-Employment Physical (99385.G)

$75 ☐ Full Spine X-ray 3 View (72082)

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$30 ☐ Blood Draw Collection (36415)

$168 ☐ Hep B Vaccine (90746)

$85 ☐ Hepatitis B Titer (86706)

$138 ☐ Hep A Vaccine (90632)

$50 ☐ Flu Vaccine (90656)

$50 ☐ PPD (TB Test) (86580)

$30 ☐ Blood Sugar Test (82948)

➡ **ALL DRUG SCREENS & BREATH ALCOHOL TESTS (Please Choose One):** ☐ **Return to Duty** ☐ **Follow-Up** ☐ **Cause/Suspicion** ☐ **Pre-Employment** ☐ **Workers Comp** ☐ **Random** ☐ **Post Injury** ☐ **Post Accident**

REQUIRED FOR ALL WORKERS' COMPENSATION VISITS

☐ Workers' Compensation Injury Treatment Date of Injury:_____ Type of Injury: _____

☐ Post Accident Drug Screen Required ➡ *Check Type Above* Has employer filled out First Report of Injury? ☐ Yes (send copy) ☐ No

☐ Post Accident DOT Drug Screen Required ➡ *Check Type Above* Breath Alcohol Testing ☐ DOT (82075.D) or ☐ Non-DOT (82075.N)

Where are claims to be filed? ☐ Bill Employer ☐ Insurance Carrier W/C Carrier Name: _____

W/C Carrier Address: _____

W/C Carrier Phone:_____ W/C Carrier Fax:_____ Policy Number: _____

BILLING INSTRUCTIONS

☐ Bill Credit Card on File

☐ Bill New Credit Card

☐ Bill Patient - Payment due at time of service ***(PSR use Fee For Service Account BT377)***

☐ Bill Established Employer Account *(account must be current - no past due balance)*

Name on Card:_____ Card Number:_____ Exp Date:_____ Code: _____

Card Address:_____ City:State:_____ Zip Code: _____

Card Type: ☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

EMPLOYER This certifies that the above information is correct. I authorize the medical provider to provide medical treatment to the employee named above. I also understand that the services provided will be paid in full by the company listed above and authorized by my signature below.

X

Employer Signature (REQUIRED) **Date** **Printed Name (REQUIRED)** Title: _____

EMPLOYEE SIGNATURE & STATEMENT

I understand that I will be responsible for payment of services indicated above should circumstances arise resulting in non-payment from my employer.

X

Employee Signature (REQUIRED) **Date**