Occupational Service Agreement

Today's Date: _____

Company Information

Company Name: _____ ☐ New Account ☐ Update

Address: _____

City: _____ State: _____ Zip: _____ Federal Tax ID# _____

Phone: _____ Fax: _____ ☐ Corporation ☐ Partnership ☐ Individual

***Please include a completed W-9 Form with agreement**

Company Contacts

Primary: _____ Title: _____

Email: _____ Phone: _____ Ext: _____

Secondary: _____ Title: _____

Email: _____ Phone: _____ Ext: _____

Send all results to this secure email address: _____

Send all results to this secure fax number: _____

Billing Information

Payment terms are net 10. I understand clients with a past due balance of 30 days or greater may be charged a $25.00 late fee for each month past due and could lose access to service until account is paid in full. _____

A/P Contact: _____ Phone: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Worker's Compensation

Authorize WellQuest to treat work-related injuries? ☐ Yes ☐ No Send WC invoices to: ☐ Insurance ☐ Employer

Drug test for initial WC visits? ☐ Yes ☐ No Type: _____ Saliva Alcohol Test? ☐ Yes ☐ No

Insurance Policy Holder's Name: _____

Insurance Company: _____ Group # _____

Claims Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Email: _____

All insurance information is correct and policy is in effect. Should the company insurance policy change, I will notify WellQuest immediately. _____

Drug Testing

☐ **GCMS LAB TESTS with MRO: ☐ 5-Panel ☐ 9-Panel On-Site Services Needed: ☐ Yes ☐ No**

☐ **In-House QUICK SCREEN TESTS: ☐ 5-Panel ☐ 9-Panel**

Send Positives for MRO Confirmation: ☐ Yes ☐ No

☐ **DOT 5-Panel with MRO**

Signature: _____ Title: _____

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