




## NEW COMPANY PROFILE AGREEMENT

COMPANY INFORMATION		
Company Name		Date
Address, City, State, Zip		
Primary Contact Name		Phone
Email		
Contact Name for Results		
Email		
Billing Contact Name		Phone
Email		
RECEIVE RESULTS	Email <input type="checkbox"/> Secure Fax <input type="checkbox"/>	Fax #
WORKERS COMP INFORMATION		
Carrier Name		Policy #
Carrier Address		Phone
		Fax #
Is Modified Duty Available?	YES <input type="checkbox"/> NO <input type="checkbox"/>	
Post- Accident Drug Screen Required?	YES <input type="checkbox"/> NO <input type="checkbox"/>	5 Panel <input type="checkbox"/> 10 Panel <input type="checkbox"/>
Bill Post- Accident Drug Screen to	Employer <input type="checkbox"/> TPA <input type="checkbox"/> WC Carrier <input type="checkbox"/>	
TPA Name		
EMPLOYER PAID SERVICES		
DRUG TESTING		
	RAPID Test in House 5 Panel <input type="checkbox"/> 10 Panel <input type="checkbox"/>	
	Send out to our Lab (Alere) 5 Panel <input type="checkbox"/> 10 Panel <input type="checkbox"/>	12 Panel <input type="checkbox"/> 24-72 hours
	DOT Drug Screen (our lab) <input type="checkbox"/> Breath Alcohol Test <input type="checkbox"/>	
	Hair Follicle Test <input type="checkbox"/> Saliva Alcohol Test <input type="checkbox"/>	
	Your Company Provided Custody Control Form (CCF) Collection Only <input type="checkbox"/>	

		
<b>PHYSICAL EXAMS</b>		
	Pre-Employment <input type="checkbox"/>	DOT Physical <input type="checkbox"/>
	Return to Work <input type="checkbox"/>	Respirator Physical <input type="checkbox"/>
	Silica/Asbestos <input type="checkbox"/>	PFT/Spirometry <input type="checkbox"/>
		OSHA Questionnaire w/ Clearance <input type="checkbox"/>
		Respirator Fit Test <input type="checkbox"/>
<b>IMMUNIZATIONS</b>		
	Hep B (series) <input type="checkbox"/>	Hep A <input type="checkbox"/>
	Tetanus, Tdap <input type="checkbox"/>	Tetanus, Diptheria <input type="checkbox"/>
		Flu Vaccine <input type="checkbox"/>
<b>LABS</b>		
	Hep B Titer <input type="checkbox"/>	MMR Titer <input type="checkbox"/>
	Blood Lead Level <input type="checkbox"/>	Varicella Titer <input type="checkbox"/>
<b>ADDITIONAL TESTING</b>		
	Audio Exam <input type="checkbox"/>	TB Skin Test <input type="checkbox"/>
	Lift Test 50lbs <input type="checkbox"/>	Lift Test 75lbs <input type="checkbox"/>
	Chest X-Ray (1 view) <input type="checkbox"/>	Chest X-Ray "B Read" <input type="checkbox"/>
	Vision (Snellen) <input type="checkbox"/>	Vision (Ishihara) <input type="checkbox"/>
	Other:	
<b>Specify any special protocol instructions</b>		
<b>BILLING AND PAYMENT INFORMATION</b>		
<p>A monthly invoice of open charges will be sent to you at the billing address on file. Customer agrees to pay the invoice due each month. If payment falls more than 90 days in arrears, your account will be put on hold. 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 inactive until resolved in full. Accounts over 120 days may be sent to collections for resolution.</p> <p>Please note Rapid drug screens are performed in our centers, and results are available immediately. Results are NOT Permissible in a court of law. If a Rapid drug screen results as non-negative, our company policy is to send to the lab for confirmation. A \$25 fee for confirmatory testing is accessed.</p> <p>Company Acknowledges _____ Initials</p>		
<b>CUSTOMER ACKNOWLEDGEMENT</b>		
<b>Authorized Person</b>		<b>Title</b>
<b>Authorized Signature</b>		
<b>Date</b>		

This agreement will remain in effect until either party gives written notice of change of service, terms or conditions. Agreement subject to annual increases. Increased will be discussed and agreed upon by all parties prior to implementation.