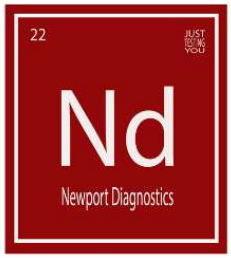
New Account/Account Change Form



DATE SUBMITTED
CLIENT START DATE
ACCOUNT#

DATE COMPLETED
SALESPERSON
BY

CLIENT (CLINIC) NAME **PHONE & FAX** **EMAIL**

ADDRESS **CITY** **ST** **ZIP**

Provider Name(s)	License #	NPI #

Office Contact(s)	Title	Phone #

Physician's Signature: _____

Days of Operation: Mon Tues Wed Thur Fri Sat Sun

From (Hours)
To (Hours)

Specimen Pick-up Schedule:

Mon - Fri ☐ Daily Before: ___PM or ☐ Call in (call for pickup before 2pm)
Saturday ☐ Daily Before: ___PM or ☐ Call in (call for pickup before 12pm)
Sunday ☐ Daily Before: ___PM or ☐ Call in (call for pickup before 2pm)

Do you require a lock box? ☐ Yes ☐ No **Do you require a centrifuge?** ☐ Yes ☐ No

Reporting Preference (please check): ☐ Fax ☐ Email ☐ Portal

Critical Value Reporting: ☐ Call all Criticals ☐ Fax all Criticals

Special Instructions:

18242 W McDurmott Ste C Irvine, CA 92614
Ph: 949.385.3535 Fx: 949.528.1313