CENTRAL TOX®

Acct # (Lab Use Only)

New Account Setup Form

Sales Representative

Affiliation

Contact Phone #

Email Address

ACCOUNT INFORMATION

PRACTICE/FACILITY NAME

PHONE #

ADDRESS

FAX #

CITY, STATE, ZIP

ESTIMATED START DATE

CONTACT NAME (FIRST & LAST – REQUIRED)

ESTIMATED MONTHLY VOLUME

CONTACT EMAIL

CONTACT PHONE #

TYPE OF FACILITY ☐ TREATMENT ☐ PAIN ☐ FAMILY CARE ☐ OTHER ___________

PROVIDER INFORMATION & AUTHORIZATION

Informed Consent: By my signature below, I authorize performance of the test(s) marked on the requisition form and affirm that I have explained the purpose of the test, the procedures, the benefits, and the risks that are involved in testing to their patient and obtained the patient's informed consent in accordance with state and local laws.

Medical Necessity: I affirm each of the following: For all requisition forms submitted from my practice, I have provided laboratory testing information to the patient and the patient has consented to laboratory testing. This test is medically necessary for the diagnosis or detection of a disease, illness, impairment, symptom, syndrome, or disorder. The results will be used for the patient's medical management and treatment decisions. The person listed as the Ordering Physician is authorized by law to order the test(s) requested. Upon request, I will produce documentation to support the medical necessity of the laboratory tests requested.

PROVIDER NAME	DEGREE/TITLE	NPI #	SIGNATURE	DATE
PROVIDER NAME	DEGREE/TITLE	NPI #	SIGNATURE	DATE
PROVIDER NAME	DEGREE/TITLE	NPI #	SIGNATURE	DATE
PROVIDER NAME	DEGREE/TITLE	NPI #	SIGNATURE	DATE
PROVIDER NAME	DEGREE/TITLE	NPI #	SIGNATURE	DATE
PROVIDER NAME	DEGREE/TITLE	NPI #	SIGNATURE	DATE

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PRACTICE/FACILITY OWNER AUTHORIZATION

Central Tox, LLC is committed to complying with all state and federal rules, regulations, and laws concerning healthcare services. In order to further ensure such compliance, Central Tox requires all owners of this facility to sign the following acknowledgement indicating they are not affiliated with any sales distribution or receiving commission payments made for referrals from this facility.

By signing below, I acknowledge that I am not affiliated with any sales distribution or receiving any kind of commission payments made for referrals from this facility. I understand the aforementioned is strictly prohibited.

______________________	______________________	______________________
OWNER NAME	SIGNATURE	DATE
______________________	______________________	______________________
OWNER NAME	SIGNATURE	DATE
______________________	______________________	______________________
OWNER NAME	SIGNATURE	DATE

PRACTICE/FACILITY INFORMATION

CLINIC HOURS: M ________ T ________ W ________ TH ________ F ________

IN-HOUSE ANALYZER? ☐ YES ☐ NO

CURRENT EMR VENDOR: __________________________ RESULTS INTERFACE? ☐ YES ☐ NO

PAYOR MIX:

______% COMMERCIAL ______% MEDICARE ______% SELF-PAY

______% MEDICAID ______% W/C OR AUTO

TRANSMISSION OF REPORTS: ☐ FAX ☐ WEB ACCESS

REQUESTED USER ID FOR PORTAL ______________________________ PASSWORD ________________________________

AUTHORIZED USER FULL NAME __________________________________ EMAIL ADDRESS ____________________________

SECURE FAX # ________________________

SUPPLIES

INDICATE QUANTITY NEXT TO ITEM

________REQUISITION FORMS _______E-REQ PAPER

________SPECIMEN CUPS (PLAIN) _______FEDEX CLINICAL PAKS _______FEDEX BOXES

________SPECIMEN BAGS _______FEDEX LABELS

SHIP TO: ☐ SALES REP *(provide address below)* ☐ PRACTICE/CLIENT

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Fax or Email Completed Form To Central Tox:
P: 512-382-9710 F: 512-382-7421 Email: CustomerService@CentralTox.com