Rep: _____

Draw Station: _____

☐Drop Off ☐Walk In

Provider Practice Information

Practice Name: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

Practice Contact

Name: _____

Email: _____ Phone: _____ FAX: _____

Result Reporting

☐Online Portal (Access to Practice Contact)

☐ Faxed to: _____ ☐Emailed to: _____ Password:_____

Acknowledgement

Date: _____

I authorize Spring Diagnostics to perform requested laboratory tests on my patients from my facility as directed on my signed orders at their primary site or any of their affiliated laboratories. I understand that it is my responsibility to determine the Medical Necessity of each / all test(s) requested. I certify that compliance with my patients / beneficiary's insurance(s) are in place, including records that reflect the need for the test(s) and document the order of the test(s). These records will be provided upon request. Further, I authorize and instruct Spring Diagnostics to provide patient lab result report access online, sending account access to the listed practice contact. I understand that other delivery methods may be initiated by contacting Spring Diagnostics. I understand that Spring Diagnostics requisitions are to be submitted to Spring Diagnostics only and that Bill Clinic invoices are to be paid on receipt.

First Name	Last Name	Title	NPI	Provider Signature
			☐Supervising Provider	

Rep: _____

Draw Station: _____

☐Drop Off ☐Walk In

Routine Testing Panel(s)

☐ Print on Practice Requisitions

Panel Type	Tests Included:
Example Panel	*-Free T4 -Total T4* *-Free T3 -TSH* *-Total T3*

Billing

Insurance

☐Private Insurance: _____% ☐Medicare: _____% ☐Medi-Cal_____% ☐Other_____%

Bill Clinic/Doctor

☐Bill Provider: _____% ☐Bill Patient: _____%

Payable Contact Information:

Name: _____ Address: _____

Email: _____ Phone: _____ FAX: _____

Estimated Start Date: _____ **Estimated Labs/Mo:** _____