ETX DIAGNOSTICS
MOLECULAR & GENETICS TESTING SPECIALISTS

Phone: 346.335.3953
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support@etxdiagnostics.net

LAB USE ONLY

Date Received: _____

Initials: _____

Joseph Cox , *Director*
***CLIA ID**: 45D2275807*
12849 Capricorn St. Stafford, TX 77477

NEW ACCOUNT REGISTRATION FORM

ACCOUNT INFORMATION

Account Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Email: _____

Account Type: ☐ Physician Group ☐ Private Physician
(Select one): ☐ Hospital ☐ Rehab Center
☐ Other: _____

PHYSICIAN ACKNOWLEDGEMENT

I have reviewed the test menu and sample reports and confirm that the labs offerings are consistent with our practice needs.

Provider Name: _____

Provider Signature: _____

PRIMARY ACCOUNT CONTACT

Contact Name and Title: _____

Contact Phone and Fax: _____

Contact Email: _____

Please note, the above contact will be used by the lab, for obtaining missing information on cases being performed by ETX Diagnostics for the above account.

ORDERING PROVIDERS *(attach list if more than 2)*

Name: _____
PECOS: _____ NPI: _____

Name: _____
PECOS: _____ NPI: _____

COLLECTOR INFORMATION

☐ **This account will have a collector.**

Collector Name: _____

Phone (Cell): _____ Hourly Rate: _____

CRITICAL AFTER HOURS (PROVIDER)

Provider Name: _____

Phone: _____ Fax _____

BILLING METHOD

☐ Insurance Billing ☐ Bill to Client

☐ Custom Billing Schedule

PROJECTED SUPPLY MANAGEMENT AND PICKUP SCHEDULE

Account Volumes (per month):

	Month 1	Month 2	Month 3
☐ Tox			
☐ Blood			
☐ DupDel			
☐ Genetics			
☐ UTI			
☐ OTHER			

SHIPPING ADDRESS

Check if address is the same as this account's physical location.

Attention: _____

Address: _____

City: _____ State: _____ Zip: _____

Email tracking number to: _____

REPORT RETRIEVAL

Reports will always be provided through our portal for eased of access. This does require logging into to retrieve them, to facilitate this process, please indicate who will be responsible for report retrieval:

Name: _____

Email: _____

☐ Collector will retrieve ☐ Providers will retrieve

ACCOUNT MANAGEMENT

Account Manager: _____

Account Manager Email: _____

Account Manager Cell: _____

By signing below the account manager listed above agrees that the client understands all testing, and requirements for ordering testing as well as retrieving reports as requested by ETX Diagnostics.

SIGNATURE: _____

All New Accounts require approval prior to processing. Please allow 3 days for New Account Registration Processing.