

# NEW CLIENT REGISTRATION FORM



Please complete registration form and fax to (832) 219-3903. You may also email form to [info@meadowslab.com](mailto:info@meadowslab.com)  
This form is for all clients whom will be sending lab orders and samples to Orange County Labs, Inc. for services.

INFECTIOUS DISEASE\_\_\_\_ MOLECULAR\_\_\_\_ WOMEN'S HEALTH\_\_\_\_ GENETICS\_\_\_\_ TOXICOLOGY\_\_\_\_ BLOOD\_\_\_\_

## CLIENT INFORMATION

Practice Name: \_\_\_\_\_ Date of Registration: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone : \_\_\_\_\_ Fax : \_\_\_\_\_

Ordering Physician's Full Name: \_\_\_\_\_ Credentials: MD/NP/PA: \_\_\_\_\_

Specialty Type: \_\_\_\_\_ License #: \_\_\_\_\_

NPI #: \_\_\_\_\_ Medicare PTAN #: \_\_\_\_\_

Ordering Physician's Full Name: \_\_\_\_\_ Credentials: MD/NP/PA: \_\_\_\_\_

Specialty Type: \_\_\_\_\_ License #: \_\_\_\_\_

NPI #: \_\_\_\_\_ Medicare PTAN #: \_\_\_\_\_

Ordering Physician's Full Name: \_\_\_\_\_ Credentials: MD/NP/PA: \_\_\_\_\_

Specialty Type: \_\_\_\_\_ License #: \_\_\_\_\_

NPI #: \_\_\_\_\_ Medicare PTAN #: \_\_\_\_\_

Ordering Physician's Full Name: \_\_\_\_\_ Credentials: MD/NP/PA: \_\_\_\_\_

Specialty Type: \_\_\_\_\_ License #: \_\_\_\_\_

NPI #: \_\_\_\_\_ Medicare PTAN #: \_\_\_\_\_

Ordering Physician's Full Name: \_\_\_\_\_ Credentials: MD/NP/PA: \_\_\_\_\_

Specialty Type: \_\_\_\_\_ License #: \_\_\_\_\_

NPI #: \_\_\_\_\_ Medicare PTAN #: \_\_\_\_\_

Other Contacts: (EMAIL MUST be filled out to receive online portal access)

Clinical Supervisor: \_\_\_\_\_ Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Operations: \_\_\_\_\_ Email: \_\_\_\_\_ Phone: \_\_\_\_\_

## BILLING CONTACT INFORMATION

Primary Contact: \_\_\_\_\_ Email: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## SPECIMEN PICKUP DAYS

Anticipated Weekly Volume: Less than 25 \_\_\_\_\_ 26 – 50 \_\_\_\_\_ 51 – 100 \_\_\_\_\_ 101 – 200 \_\_\_\_\_

EMV \$: \_\_\_\_\_

COURIER \_\_\_\_\_ DROP-OFF \_\_\_\_\_ FED-EX \_\_\_\_\_ UPS \_\_\_\_\_ PICK-UP TIME \_\_\_\_\_

MONDAY \_\_\_\_\_ TUESDAY \_\_\_\_\_ WEDNESDAY \_\_\_\_\_ THURSDAY \_\_\_\_\_ FRIDAY \_\_\_\_\_

## TEST REPORT DELIVERY METHOD (For Office Use Only)

ONLINE PORTAL \_\_\_\_\_ FAX \_\_\_\_\_ ENCRYPTED MAIL \_\_\_\_\_ COURIER \_\_\_\_\_ EMR INTERFACE \_\_\_\_\_

## PHYSICIAN/PRACTITIONER AGREEMENT

1. I authorize Meadows Diagnostics to perform testing on my patients from my practice as directed by the individual requisition forms as well as my predefined custom profile on file, if applicable. I understand that it is my option to use a predefined custom profile or select specific tests on the compliant **completed** test requisition form.
2. By signing this form, it is hereby certified that the treating physician shall review the volume, frequency, and duration of testing and order laboratory testing accordingly and in accordance with clinical indication and medical necessity. I understand that it is my responsibility to determine the medical necessity of tests I have requested for the treatment and/or diagnosis of my patients. I agree to provide diagnosis codes, defined to the highest level of specificity, for each test that I order to confirm medical necessity and to enable Orange County Labs, Inc. to bill on my patient's behalf.
3. I further understand that according to Medicare, "Confirmation of drug screens is indicated when the result of the drug screen is different than that suggested by the patient's medical history, clinical presentation, or patient's own statement."
4. By signing this form, I acknowledge if any Point of Care (POC) device is provided by the lab I will not directly or indirectly bill or collection fee for POC testing without submitting payment to the lab for the device at a fair market value rate. I agree and understand the device will be used solely to collect, transport, process, or store specimens referred to the lab for testing. I acknowledge and understand that use of the POC device for any other purpose or billing for POC testing with laboratory-provided POC devices without remitting payment for same to the lab could be interpreted as a violation of Anti-Kickback Statue 42 U.S. C. § 1320a-7b.
5. I understand that the Office of the Inspector General (OIG) has cautioned: "Using a customized profile may result in the ordering of test which are not covered, reasonable or necessary. OIG takes the position that an individual who knowingly causes a false claim to be submitted may be subject to sanctions or remedies available under civil, criminal, and administrative law."
6. I understand that Orange County Labs, Inc. will be billing third parties for the tests I ordered. I will provide signed written orders for the patient's medical records to the requesting party or Orange County Labs, Inc. within 72 hours.
7. I verify that I am ordering testing to be performed at Orange County Labs, Inc. and its affiliated contracted laboratories.
8. My predefined custom profile will be valid for 365 days from the date of signature. I understand I may request changes to my predefined custom profile at any time. The signatories hereto understand there may be applicable National Coverage Determinations and Local Coverage Determinations for clinical laboratory testing.
9. I understand that Orange County Labs, Inc. reflects the views, recommendations and guidelines outlined in the CMS National Coverage Policy. I acknowledge Orange County Labs, Inc. has provided me with information regarding its policies and guidelines for laboratory testing to my satisfaction.
10. I authorized Orange County Labs, Inc. to upload my signature from the signature box below to the online portal and keep it on file. I acknowledge my signature will be used by Orange County Labs, Inc. for all laboratory records and medical records requested by the insurance company. I acknowledge that I can add a signature, update my signature, and remove my signature at any time by written request.

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Physician/ Practitioner Name

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Physician/Practitioner NPI

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Date

Physician/Practitioner Signature  
(Please sign above for signature upload)

# NEW CLIENT REGISTRATION FORM



## PROTECTED HEALTH INFORMATION (PHI) PORTAL ACCESS AGREEMENT FOR CLIENT USERS

This Agreement is entered into on this \_\_\_\_\_ day of \_\_\_\_\_, by and between Orange County Labs, Inc. and \_\_\_\_\_, an employee of the following client \_\_\_\_\_ located at: \_\_\_\_\_.

WHEREAS, Meadows Diagnostics makes accessible to the following users its Electronic Medical Online Portal, which contains a broad range of electronically stored medical information about patients, doctors and their medical history and results, including Protected Health Information as herein defined. Meadows Diagnostics wishes to allow User to have access to the Electronic Medical Online Portal so that User may access such medical information needed by User to provide healthcare and/or healthcare services for patients; NOW, THEREFORE, in consideration of the mutual promises contained herein, the parties agree as follows:

### I. CONDITIONS

- (a) Will not share or give his/her user or password to any other individual, or will take the appropriate measures to safeguard his/her credentials;
- (b) To not use or disclose patient Protected Health Information other than as permitted or as required by law;
- (c) To use appropriate safeguards and practices to prevent use or disclosure of the patient Protected Health Information other than as provided for in this Agreement.
- (d) If documents are printed for patient care, they should be kept secure while in use and shredded when no longer needed.
- (e) Printed documents may not be removed from the healthcare facility unless being given to laboratory for lab results.
- (f) The user will log out of the application before leaving the computer for any certain amount of time.
- (g) To mitigate, to the extent practicable, any harmful effect that is known to User of a use or disclosure of Protected Health Information in violation of the requirements of this Agreement;
- (h) To comply with all applicable federal and state laws and regulations which protect the confidentiality of Protected Health Information;
- (i) To not act or fail to act in a way that would cause OC LABS, INC. to be noncompliant with applicable federal or state laws or regulations which protect the confidentiality of protected health information;
- (j) To promptly notify Orange County Labs, Inc. when changes occur in his/her practice or job duties which would eliminate or materially affect his/her status or stated justification for access to Electronic Medical Online Portal.
- (k) To promptly report to Orange County Labs, Inc. at (832) 219-3903 or info@meadowslab.com any use or disclosure of Protected Health Information of which he/she becomes aware which would violate the terms of this Agreement.

### II. TERMS OF ACCESS

User agrees to the following once she/he has access to Electronic Medical Online Portal from Orange County Labs, Inc.:

- (a) Electronic Medical Online Portal access is protected health information only for the sole purpose of retrieving and providing healthcare services.
- (b) Information, including Protected Health Information, accessed and/or retrieved from the Electronic Medical Online Portal, is intended only for the review and/or use of the authorized user for legitimate medical needs.
- (c) User's access to the Electronic Medical Online Portal will be recorded electronically, and Electronic Medical Online Portal access and use will be audited by Meadows Diagnostics at any time on a random basis or for cause.
- (d) This agreement is a guarantee until the end of the calendar year and must be renewed every year or when there is a modification, Orange County Labs, Inc. will inform all users in writing.

### III. TERMINATION

Meadows Diagnostics has the right to immediately terminate this agreement and discontinue access to the Electronic Medical Online Portal at any time for any reason.

### IV. INDEMNIFICATION

User shall be responsible for any breach of this agreement, whether by User or by User's agents, representatives, or employees. User shall defend, indemnify, and hold Orange County Labs, Inc. harmless from all damages, costs, expenses and fees (including attorneys' fees) resulting from such breach. Please complete below with your requested user name and email for notifications.

USER NAME	SIGNATURE	EMAIL	DATE

# NEW CLIENT REGISTRATION FORM

For office use only.



## SUPPLY REQUEST FORM

Practice Name: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
Email: \_\_\_\_\_

### STARTER KITS

Specimen Cups Qty: \_\_\_\_\_ Swabs (RPP/COVID/TNP/PGx) Qty: \_\_\_\_\_ Urine Vac tubes (Additive/Non Add) Qty: \_\_\_\_\_  
SST Tubes Qty: \_\_\_\_\_ Red Top Tubes Qty: \_\_\_\_\_ Lav Tubes Qty: \_\_\_\_\_ Grey Tubes Qty: \_\_\_\_\_  
21g Needles Qty: \_\_\_\_\_ Bx 22g Needles Qty: \_\_\_\_\_ Hubs Qty: \_\_\_\_\_ Bandage Tape Qty: \_\_\_\_\_

### SPECIMEN CUPS

Speciment Collection Cups Qty: \_\_\_\_\_

### COLLECTION SUPPLIES

Speciment Bags (100 per pkg) Qty: \_\_\_\_\_

### LAB REQUEST FORMS

Blank Reqs (100 per pkg) Qty: \_\_\_\_\_

### MAILING SUPPLIES

Fed-Ex Shipping Bags Qty: \_\_\_\_\_ Shipping Labels Qty: \_\_\_\_\_  
UPS Shipping Bags Qty: \_\_\_\_\_ Shipping Labels Qty: \_\_\_\_\_

*Supplies are mailed GROUND or 2 DAY. Supplies can be delivered by courier or picked up. Please allow a business day for courier drop off or pick up.*

### SPECIAL SERVICE REQUEST

### OFFICE USE

RECEIVED DATE: \_\_\_\_\_  
Approval DATE: \_\_\_\_\_

Approval By Employee : \_\_\_\_\_  
Final Approval : \_\_\_\_\_