|  |  |  |  |
| --- | --- | --- | --- |
|  | NEW ACCOUNT FORM | Logo, company name  Description automatically generated |  |

|  |
| --- |
| **PRACTICE INFORMATION (Please Print)** |
| **Practice Name:** | **Primary Contact Name:** |
| **Street Address:** | **Email:** |
| **City, State, Zip:** | **Practice Tax ID#:** |
| **Phone:** | **Fax:** |
| **Medical Professional Authorization** |
| **Provider’s Name**  | 1. | 2. |
| **NPI:** |  |  |
| **License # and State:** |  |  |
| **Signature:** |  |  |
| **Provider’s Name**  | 3. | 4. |
| **NPI:** |  |  |
| **License # and State:** |  |  |
| **Signature:** |  |  |
| **Provider’s Name**  | 5. | 6. |
| **NPI:** |  |  |
| **License # and State:** |  |  |
| **Signature:** |  |  |
| I hereby authorize and instruct Shepard Health to create an account for the above location and to run samples I send to a laboratory within their facility. This standing order represents my determinations that it is both medically necessary and a matter of the prudent practice of medicine to have the ability to run the testing selected below. I understand that this order will remain in effect until an updated new account form is completed. I also understand that I may change this order, on a case-by-case basis, by making my testing preferences clear on the laboratory service requisition form. |

|  |
| --- |
| **TESING OPTIONS** |
|  |  RPP / COVID 19 |  | Optimized UTI |  | Wound Care |
| **SUPPLIES** |
| **Supplies** | **QTY** | **Shipping Supplies** | **QTY** |
|  | Respiratory Collection Kits |  |  | Shipping boxes/bags (Qty 20 pcs)  |  |
|  | UTI Collection Kits |  |  | Shipping Labels  |  |
|  | Wound Collection Kits |  |  |  |  |
| **SHIPPING INFORMATION** |
|  | SHIPPING ACCOUNT/ Pick Up Not Needed |  |
|  | Daily 1-hour pick-up window:  |
|  | Will call SHIPPER as needed |
|  | Day specific pick-up |
| **RESULTING DELIVERY PREFERENCES** |   | Web Portal  |  | FAX |