ACCOUNT APPLICATION AND UPDATE FORM

☐ **Open New Account** ☐ **Update Existing Account**

PRIMARY PRACTITIONER

Name: _____ Degree: _____ NPI: _____

PECOS (Medicare) status: ◯ Enrolled ◯ Opted-Out ◯ Unknown Signature: **X** _____

Required: *Please attach a copy of your license or voided prescription form.*

PRACTICE/CLINIC PHYSICAL LOCATION (CANNOT BE A PO BOX)

Practice/Clinic Name: _____ Main Phone: _____ Extension: _____

Address 1: _____ Other Phone: _____ Description: _____

Address 2: _____ Fax: _____

City: _____ State/Province: _____ Email: _____

Postal Code: _____ Country: _____ Email 2: _____

ADMINISTRATIVE CONTACTS

Lab Contact/Title: _____ Phone: _____ Email: _____

Office Contact/Title: _____ Phone: _____ Email: _____

Shipping Contact/Title: _____ Phone: _____ Email: _____

Billing Contact/Title: _____ Phone: _____ Email: _____

COURIER ADDRESS FOR TEST KITS (CANNOT BE A PO BOX)

◯ Same as practice/clinic physical location

Name/Attention: _____

Address 1: _____

Address 2: _____

City: _____ State/Province: _____

Postal Code: _____ Country: _____

OPTIONAL ALTERNATE ADDRESS (PO BOXES ACCEPTED)

Can be used for bills and other mail.

◯ Use practice address ◯ Use courier address

Name/Attention: _____

Address 1: _____

Address 2: _____

City: _____ State/Province: _____

Postal Code: _____ Country: _____

US & CANADA REPORT DELIVERY METHODS

All accounts have online access to results. If selected, Doctor's Data will mail hard copy reports to US & Canada clients.

◯ Mail hard copy reports (N/A outside US & Canada). Mail to: ◯ Physical Location ◯ Courier Address ◯ Alternate Address

◯ Don't mail hard copy reports; download only. Email "results ready" notification to: _____

HOW DID YOU HEAR ABOUT US?

◯ Conference: _____ ◯ Email/Newsletter ◯ Website ◯ Referred by: _____ ◯ Other: _____

EMAIL OPT-IN ADDRESS

◯ Check here to opt-in an email address to receive promotional and informative emails. We will never sell your name to any other party and you can opt out at any time by contacting us at info@doctorsdata.com

Email Address: _____

3755 Illinois Avenue
St. Charles, Il 60174-2420
800.323.2784 (US AND CANADA)
0871.218.0052 (UK)
+1.630.377.8139 (GLOBAL)
630.587.7860 (FAX)
doctorsdata.com

FOR DOCTOR'S DATA USE ONLY:

DATE RECEIVED: _____

DATE ENTERED: _____

ENTERED BY: _____

ACCOUNT #: _____

E12.18

FINANCIAL RESPONSIBILITY FORM

BILLING PREFERENCE

- ○ **Enable all billing methods** *and bill as requisition is marked (Default billing method)*
- ○ **Never bill practitioner account;** *only allow patient prepay, or insurance/Medicare. (Required in NY, NJ, & RI)*
- ○ **Always bill practitioner account;** *no patient payments, or insurance/Medicare billing. (N/A in NY, NJ, & RI; Required outside USA))*

WHERE DO YOU WANT YOUR BILLS SENT?

○ Physical Location ○ Courier Address ○ Alternate Address ○ Email Address _____

CREDIT CARD AUTHORIZATION

Providing a credit card on file is optional for US accounts and mandatory for all accounts outside the US.

I authorize Doctor's Data, Inc. to charge my outstanding monthly balance to this credit or debit card each month.

Card Type: ○ Visa ○ MasterCard ○ American Express ○ Discover

Name on Card: _____

Card Number: _____ Expires: _____

Cardholder Signature: **X** _____

CREDIT CARD BILLING ADDRESS

Name/Attention: _____

Address 1: _____

Address 2: _____

City: _____ Province: _____

Postal Code: _____ Country: _____

PROMPT PAYMENT AGREEMENT

I wish to participate in the Doctors Data, Inc./Labrix Prompt Payment/Professional Price Discount program. I understand that tests will be charged according to the current Prompt Payment/Professional Price Fee Schedule(s), unless otherwise described below, and I agree to comply with the following:

I understand that if I mark the requisition "Bill Practitioner Account" or select "Always Bill Practitioner Account" option below, charges will be billed to my account, and I agree to pay all outstanding balances in full within 30 days of the invoice date. I understand that all accounts are subject to credit review/approval, that credit limits may be established and that unpaid balances over 30 days old are subject to a monthly service charge of 1.5%.

I understand that patient prepayments on Doctor's Data tests will be charged according to the DDI Prompt Payment Fee Schedule; and that patient prepayments for Labrix tests will be charged according to the Labrix Proffessional Price Fee Schedule.

I understand that the Prompt payment/Professional Price fee schedules are not available when "Patient billing or Insurance/Medicare billing" is selected and that these tests will be charged according to the List Price fee schedule.

The undersigned agrees to be responsible for payment for tests billed to his or her professional account and to comply with the terms listed above:

Name: _____ Signature: **X** _____ Date: 9/17/2025

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FOR DOCTOR'S DATA USE ONLY:
DATE RECEIVED: _____
DATE ENTERED: _____
ENTERED BY: _____
ACCOUNT #: _____