

# NEW ACCOUNT FORM



Date: \_\_\_\_\_  
Sales Group: \_\_\_\_\_  
Sales Representative: \_\_\_\_\_  
Rep Phone/Email: \_\_\_\_\_  
Projected Start Date: \_\_\_\_\_

1408 Horizon Avenue, Suite 101, Lafayette, CO 80026  
Phone: (720) 726-2130 | Fax: (720) 863-2042  
info@tesislabs.com

Phlebotomist to be hired\*     Collector to be hired\*    \* Please fill out the attached collector/phlebotomist request.

## 1.0 Account Information

Account Name	Office Hours	Address	Phone	Fax

## 2.0 Physician Information

Name (M.D., D.O., CRNP)	NPI	

## 3.0 Office Contact Information

Name	Phone	Job Title

## 4.0 Account Preferences

Pick-Up:     Will-Call     Daily     UPS     Courier / UPS     Daily, Specific Days: \_\_\_\_\_  
Drop Box Location: \_\_\_\_\_  
Pick-Up Special Instructions: \_\_\_\_\_  
Report Delivery:     Fax     Web Portal     Hard Copy     EMR Integration  
Interface Request:     EMR Name: \_\_\_\_\_    EMR Contact/Phone \_\_\_\_\_  
Hardware Request:     High Speed Line     Remote printer     Computer     Label Printer  
Critical/Malignancy Calls:     Critical Clinical Results     Malignancy  
After Hours Phone #: \_\_\_\_\_

## 5.0 Billing Information

Commercial Insurance (%)     Client Bill     Workers Comp.     Medicare / Medicaid  
Estimated Monthly Volume: \_\_\_\_\_

## 6.0 Supply Request

Pathology     Toxicology     Clinical     Requisitions (Quantity/Type): \_\_\_\_\_  
 Send Supplies to Acct Representative     Send to Account Attn: \_\_\_\_\_

Physician Name (printed): \_\_\_\_\_ Physician Signature: \_\_\_\_\_

Date Signed: \_\_\_\_/\_\_\_\_/\_\_\_\_  
**FOR ALL NEW ACCOUNTS, WE MUST RECEIVE CONFIRMATION OF THE DOCTORS SIGNATURE. PLEASE HAVE DOCTOR SIGN OFF AND ACKNOWLEDGE THEIR SIGNATURE ON PRESCRIPTION PAD.**