GENTOX
Medical Services

UNIVERSAL NEW ACCOUNT SET-UP FORM

Todays Date:

Gentox Representative:	Phone #:	Email:	Intl:

Practice/Clinic/Facility Information:

Name:	Phone:
Address:	Fax:

City:	State:	Zip:	Suite #:	How Many Locations:

Office Manager/Point of Contact:	Clinic/Facility Email:

Office Hours and Days of Operation:

Mon		Tues		Wed		Thurs		Fri	

Reporting Preference: (All results will be delivered HIPAA Compliant)

FAX RESULTS: HIPAA Fax #	WEB PORTAL: # of Log-in's	EMR INTIGRATION: EMR Name	EMAIL: HIPAA Email Adress

Ship Kits to: X	Rep	Dr.	# of Kits:	PGx:	CardioGx:	OncoGx:	Blood Tox:	Urine Tox:	PCR:	Skin Biopsy:	HWC:	T&Z	Allergy:

Physician Acknowledgment of Services:

By Signing and initialing below, I am exclusively committing to the following GENTOX MEDICAL SERVICES. There is no minimum or maximum commitment. I am signing on behalf of myself and not on behalf of the clinic/facility or any other provider within. I am authorizing GENTOX affiliated labs to make lab results available through the above preference.

Physician/Provider:

Print:	Sign:	Degree Type:

Please Initial Each Applicable Box:

NPI #:	PGx:	CardioGx:	OncoGx:	Blood Tox:	Urine Tox:	PCR:	Skin Biopsy:	HWC:	T&Z	Allergy:

Physician/Provider:

Print:	Sign:	Degree Type:

Please Initial Each Applicable Box:

NPI #:	PGx:	CardioGx:	OncoGx:	Blood Tox:	Urine Tox:	PCR:	Skin Biopsy:	HWC:	T&Z	Allergy:

Physician/Provider:

Print:	Sign:	Degree Type:

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