10333 E. 21st Street North, Suite 103, Wichita, KS 67206
316-558-5850 www.chronicinflammationtest.com/lab

Step 1: Complete Information Below:

NAME OF PRACTICE: ____

NAME(S) OF HEALTHCARE PROVIDER(S) WHO WILL UTILIZE TESTING:

____

ADDRESS/CITY/STATE/ZIP/COUNTRY: ____

PHONE NUMBER: ____

FAX NUMBER: ____

EMAIL: ____

ADMINISTRATIVE CONTACTS: ____

OFFICE CONTACT/TITLE: ____

PHONE: ____

EMAIL: ____

NEW ACCOUNT APPLICATION FORM

CLINIC DISTRIBUTION METHOD

(PLEASE INDICATE WHICH OPTION YOU'D PREFER)

☐ **OPTION 1: INDIVIDUAL PATIENT REQUISTION - CLINIC PAY**

☐ **OPTION 2: ADVANCE PURCHASE DISTRIBUTION- CLINIC PAY**

☐ **OPTION 3: ONLINE PATIENT ORDERING - PATIENT PAY**

☐ **OPTION 4: IN HOUSE DISTRIBUTION/ONLINE ORDERING - PATIENT PAY**

CREDIT CARD AUTHORIZATION

Title/Position: ____

Providing a credit card on file is required for all accounts requesting advanced purchasing of kits.

Type of Card:______________________ Name on Card: ______________________________

Card Number: _______________________________ Expiration Date: _____________________________

Billing Zip Code: ___________________ Security Code: ______________________________

By providing credit card information you authorize Creative Clinical Concepts (a partner of Inflammatory Markers Laboratory) to charge your credit card. I understand that if my payment fails to process for any reason and/or if I do not provide adequate and accurate information, I will be notified by Inflammatory Markers Laboratory.

Cardholder Signature:

LAB RESULT VERIFICATION INFORMATION

Step 3: Complete Information below on results reporting.

Please advise Inflammatory Markers Laboratory on how you'd like test results reported:

☐ **Practitioner only**

☐ **Practitioner and Patient**

The undersigned health care provider hereby authorizes Inflammatory Markers Laboratory and its subsidiaries to send patient protected health information (PHI) as defined by HIPAA (Health Insurance Portability and Accountability Act of 1996) to the fax number, email or address below. (All emails from IML will be sent via a HIPPA email account) Additionally, the undersigned health care provider understands it has deemed such transmission is necessary for the purposes of health care treatment, payment, and/or health care operations.

Please indicate the preferred method of score reporting, and updates in information by checking the boxes below. Please type/write in the number and addresses for each option you choose. If more than one method is preferred; please check the corresponding boxes for each method.

☐EMAIL ACCOUNT/ADDRESS ___________________________

☐FAX NUMBER/NUMBER _____________________________

Step 4: Sign and Return

The undersigned health care provider may revoke this authorization or change fax number or method of delivery at any time as long as the health care provider gives IML written notice.

IML strongly encourages all clients to physically safeguard fax machines, computers, etc. so access and use of such machines comply with all HIPAA requirements.

Health Care Provider Name: ____

Health Care Practice Name & Address: ____

Signed By:
Authorized Signature: Print Name: Date: