



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

NEW ACCOUNT APPLICATION FORM

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: _____

CLINIC DISTRIBUTION METHOD

(PLEASE INDICATE WHICH OPTION YOU'D PREFER)

- OPTION 1: INDIVIDUAL PATIENT REQUISITION - CLINIC PAY

- OPTION 2: ADVANCE DEPOSIT- 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 HIPAA 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: _____