NEW CLIENT REGISTRATION FORM

OC LABS

Please complete registration form and fax to 714-902-6994. You may also email form to info@orangecountylabs.com

INFECTIOUS DISEASE____ MOLECULAR____ WOMEN'S HEALTH____ GENETICS____ TOXICOLOGY____ BLOOD____

CLIENT INFORMATION

Practice Name:____ Date of Registration:____________
Address:____ City:________________ State: _____ Zip Code:_______
Phone : ________________________________ Fax : ________________________________

Ordering Physician's Full Name: ________________________________ Credentials: MD/NP/PA: _________
Specialty Type: ________________________________ License #: ________________________
NPI #: ________________________________ Medicare PTAN #: ________________________

Ordering Physician's Full Name: ________________________________ Credentials: MD/NP/PA: _________
Specialty Type: ________________________________ License #: ________________________
NPI #: ________________________________ Medicare PTAN #: ________________________

Ordering Physician's Full Name: ________________________________ Credentials: MD/NP/PA: _________
Specialty Type: ________________________________ License #: ________________________
NPI #: ________________________________ Medicare PTAN #: ________________________

Ordering Physician's Full Name: ________________________________ Credentials: MD/NP/PA: _________
Specialty Type: ________________________________ License #: ________________________
NPI #: ________________________________ Medicare PTAN #: ________________________

Ordering Physician's Full Name: ________________________________ Credentials: MD/NP/PA: _________
Specialty Type: ________________________________ License #: ________________________
NPI #: ________________________________ Medicare PTAN #: ________________________

Other Contacts: (EMAIL MUST be filled out to receive online portal access)
Clinical Supervisor:________________________ Email:________________________ Phone:______________
Operations:________________________ Email:________________________ Phone:______________

BILLING CONTACT INFORMATION

Primary Contact:________________________ Email:________________________
Phone:________________________ Fax:________________________

SPECIMEN PICKUP DAYS

Anticipated Weekly Volume: Less than 25 ________ 26 – 50 ________ 51 – 100 ________ 101 – 200 ________
EMV $: ________________________
COURIER____________ DROP-OFF___________ FED-EX_____________ UPS_______________ PICK-UP TIME_________________
MONDAY____________ TUESDAY___________ WEDNESDAY_________________ THURSDAY__________ FRIDAY_____________

TEST REPORT DELIVERY METHOD

ONLINE PORTAL _______ FAX _______ ENCRYTED MAIL _______ COURIER _______ EMR INTERFACE ___________

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PHYSICIAN/PRACTITONER AGREEMENT

1. I authorize Orange County Labs, Inc. (OC LABS, INC.) to perform testing on my patients from my practice as directed by the individual requisition forms as well as my predefined custom profile on file, if applicable. I understand that it is my option to use a predefined custom profile or select specific tests on the test requisition form.

2. By signing this form, it is hereby certified that the treating physician shall review the volume, frequency, and duration of testing and order laboratory testing accordingly and in accordance with clinical indication and medical necessity. I understand that it is my responsibility to determine the medical necessity of tests I have requested for the treatment and/or diagnosis of my patients. I agree to provide diagnosis codes, defined to the highest level of specificity, for each test that I order to confirm medical necessity and to enable OC LABS, INC. to bill on my patient's behalf.

3. I further understand that according to Medicare, "Confirmation of drug screens is indicated when the result of the drug screen is different than that suggested by the patient's medical history, clinical presentation, or patient's own statement."

4. By signing this form, I acknowledge if any Point of Care (POC) device is provided by the lab I will not directly or indirectly bill or collection fee for POC testing without submitting payment to the lab for the device at a fair market value rate. I agree and understand the device will be used solely to collect, transport, process, or store specimens referred to the lab for testing. I acknowledge and understand that use of the POC device for any other purpose or billing for POC testing with laboratory-provided POC devices without remitting payment for same to the lab could be interpreted as a violation of Anti-Kickback Statue 42 U.S. C. § 1320a-7b.

5. I understand that the Office of the Inspector General (OIG) has cautioned: "Using a customized profile may result in the ordering of test which are not covered, reasonable or necessary. OIG takes the position that an individual who knowingly causes a false claim to be submitted may be subject to sanctions or remedies available under civil, criminal, and administrative law."

6. I understand that OC LABORATORIES will be billing third parties for the tests I ordered. I will provide signed written orders for the patient's medical records to the requesting party or OC LABORATORIES within 72 hours.

7. I verify that I am ordering testing to be performed at OC LABORATORIES and its affiliated contracted laboratories.

8. My predefined custom profile will be valid for 365 days from the date of signature. I understand I may request changes to my predefined custom profile at any time. The signatories hereto understand there may be applicable National Coverage Determinations and Local Coverage Determinations for clinical laboratory testing.

9. I understand that OC LABORATORIES reflects the views, recommendations and guidelines outlined in the CMS National Coverage Policy. I acknowledge OC LABORATORIES has provided me with information regarding its policies and guidelines for laboratory testing to my satisfaction.

10. I authorized OC LABORATORIES to upload my signature from the signature box below to the online portal. I acknowledge my signature will be used by the laboratory for all laboratory records and medical records requested by the insurance company. I acknowledge that I can add a signature, update my signature, and remove my signature at any time directly on the online portal.

Physician/ Practitioner Name	Physician/Practitioner NPI	Date

Physician/Practitioner Signature
(Please sign above for signature upload)

NEW CLIENT REGISTRATION FORM

PROTECTED HEALTH INFORMATION (PHI) PORTAL ACCESS AGREEMENT FOR CLIENT USERS

This Agreement is entered into on this _____ day of _____, by and between OC LABS, INC. and _____, an employee of the following client_____ located at: _____. WHEREAS, OC LABS, INC. makes accessible to the following users its Electronic Medical Online Portal, which contains a broad range of electronically stored medical information about patients, doctors and their medical history and results, including Protected Health Information as herein defined. OC LABS, INC. wishes to allow User to have access to the Electronic Medical Online Portal so that User may access such medical information needed by User to provide healthcare and/or healthcare services for patients; NOW, THEREFORE, in consideration of the mutual promises contained herein, the parties agree as follows:

I. CONDITIONS

In consideration for use of the Electronic Medical Online Portal, User agrees to the following terms and conditions

(a) Will not share or give his/her user or password to any other individual, or will take the appropriate measures to safeguard his/her credentials;
(b) To not use or disclose patient Protected Health Information other than as permitted or as required by law;
(c) To use appropriate safeguards and practices to prevent use or disclosure of the patient Protected Health Information other than as provided for in this Agreement.
(d) If documents are printed for patient care, they should be kept secure while in use and shredded when no longer needed.
(e) Printed documents may not be removed from the healthcare facility unless being given to laboratory for lab results.
(f) The user will log out of the application before leaving the computer for any certain amount of time.
(g) To mitigate, to the extent practicable, any harmful effect that is known to User of a use or disclosure of Protected Health Information in violation of the requirements of this Agreement;
(h) To comply with all applicable federal and state laws and regulations which protect the confidentiality of Protected Health Information;
(i) To not act or fail to act in a way that would cause OC LABS, INC. to be noncompliant with applicable federal or state laws or regulations which protect the confidentiality of protected health information;
(j) To promptly notify OC LABS, INC when changes occur in his/her practice or job duties which would eliminate or materially affect his/her status or stated justification for access to Electronic Medical Online Portal.
(k) To promptly report to OC LABS, INC at 714-894-1951 or sales@orangecountylabs.com any use or disclosure of Protected Health Information of which he/she becomes aware which would violate the terms of this Agreement.

II. TERMS OF ACCESS

User agrees to the following once she/he has access to Electronic Medical Online Portal from OC LABS, INC.:

(a) Electronic Medical Online Portal access is protected health information only for the sole purpose of retrieving and providing healthcare services.
(b) Information, including Protected Health Information, accessed and/or retrieved from the Electronic Medical Online Portal, is intended only for the review and/or use of the authorized user for legitimate medical needs.
(c) User's access to the Electronic Medical Online Portal will be recorded electronically, and Electronic Medical Online Portal access and use will be audited by OC LABS, INC. at any time on a random basis or for cause.
(d) This agreement is a guarantee until the end of the calendar year and must be renewed every year or when there is a modification, OC LABS, INC. will inform all users in writing.

III. TERMINATION

OC LABS, INC. has the right to immediately terminate this agreement and discontinue access to the Electronic Medical Online Portal at any time for any reason.

IV. INDEMNIFICATION

User shall be responsible for any breach of this agreement, whether by User or by User's agents, representatives, or employees. User shall defend, indemnify, and hold OC LABS, INC. harmless from all damages, costs, expenses and fees (including attorneys' fees) resulting from such breach.

_____	_____	_____	_____
USER NAME	**SIGNATURE**	**EMAIL**	**DATE**
_____	_____	_____	_____
USER NAME	**SIGNATURE**	**EMAIL**	**DATE**

NEW CLIENT REGISTRATION FORM

OC LABS

SUPPLY REQUEST FORM

Practice Name:_____

Address:_____City:_____State: _____ Zip Code:_____

Contact:_____ Phone:_____

Email:_____

STARTER KITS

Specimen Cups Qty: _____ Swabs (RPP/COVID/TNP/PGx) Qty: _____ Urine Vac tubes (Addative/Non Add) Qty: _____ SST Tubes Qty: _____ Red Top Tubes Qty: _____ Lav Tubes Qty: _____ Grey Tubes Qty: _____

21g Needles Qty: _____Bx 22g Needles Qty : _____ Hubs Qty : _____ Bandage Tape Qty: _____

SPECIMEN CUPS

Speciment Collection Cups Qty: _____

COLLECTION SUPPLIES

Speciment Bags (100 per pkg) Qty: _____

LAB REQUEST FORMS

Blank Reqs (100 per pkg) Qty: _____

MAILING SUPPLIES

Fed-Ex Shipping Bags Qty: _____ Shipping Labels Qty: _____

UPS Shipping Bags Qty: _____ Shipping Labels Qty: _____

Supplies are mailed GROUND or 2 DAY. Supplies can be delivered by courier or picked up. Please allow a business day for courier drop off or pick up.

SPECIAL SERVICE REQUEST

OFFICE USE

RECEIVED DATE: _____ RECEIVED BY: _____

SCHEDULE DATE: _____ TIME: _____