Medical Director: Mario Kohan, M.D.
CLIA No. 05D0907431 • CAP No. 8857432
4229 Birch St. Ste 130, Newport Beach, CA 92660
Tel: 800-219-6542 • Fax: 949-272-3252

LAB SERVICE AGREEMENT

INSTRUCTIONS

1. PRINT CLEARLY when providing required information to ensure timely processing; attach additional pages as needed.
2. Upon completion, FAX this form to: 949-272-3252; OR EMAIL this form to: cs@nextgenlabs.com

SALES REP INFORMATION *(required)*

Last Name:	First Name:	Phone No.:	Email Address:	Date:

PRIMARY ACCOUNT LOCATION INFORMATION *(required)*

Practice/Facility/Clinic Name: Facility ID: Office Contact Name: Email Address:

Practice/Facility/Clinic Address: City: State: Zip Code:

Phone No.: Afterhours Phone No. (for critical results): Fax No.:

Projected monthly sample volume: Projected Start Date:

Type of Facility

☐ Behavioral Health ☐ Doctor's Office/ Clinic ☐ Detox/ Residential Treatment Facility ☐ Hospital ☐ Other: ________ (specify) Number of Beds ____

TEST ORDER INFORMATION *(required)*

Select desired tests below and provide anticipated monthly volumes

☐ Toxicology ________ ☐ Infectious Disease _________ ☐ Hematology/Chemistry:_________ Other__________

Type of Report(s) desired:

☐ Basic Lab ☐ Med Management A ☐ Med Management D ☐ Cumulative

MEDICAL PROVIDER INFORMATION *(required) (attach additional names if needed)*

	Medical Provider Name (Last, First)	Specialty	National Provider ID No. (NPI)	Phone No.	Email Address
1					
2					
3					
4					
5					

Approved Person(s) to have access to Results Report and Web-Portal (required)

	Name (Last, First)	Phone No.	E-mail Address
1			
2			
3			
4			

ACCOUNT REQUESTS *(required)*

Reporting Preference:

☐ Web Portal (Lab Nexus)

☐ Fax* ☐ Email ☐ EMR/HER Name:____________________

****NGL requires that clients supply us with the access phone number of a physically secured FAX machine and assumes responsibility that access to that machine is restricted to the physician and staff members to prevent the unauthorized release of PHI.***

Specimen Delivery Options:

☐ Courier ☐ Deliver ☐ Fed-Ex ☐ Other:_________________*(specify)*

Frequency:

☐ Weekly ☐ Daily ☐ M/W/F ☐ T/TH ☐ Other __________________

I hereby certify that the above information given are true and correct as to the best of my knowledge. By signing below, I authorize NextGen Labs to provide report and result access to the aforementioned individuals.

Medical Provider's *Full* Name	Medical Provider's Signature	Date