

METAMETRIX ACCOUNT AGREEMENT

Confidential Client Information

Clinician Name:		Degree:	Account #:
Specialty:			
Company Name:			
Company Type: (circle one) Corporation Partnership Solo Practice Individual Ltd. Other			
Address:			
City:		State:	Zip:
Telephone: ()		Fax: ()	
E-Mail:			
Bill to Address (If different than above):			
Accounts Payable Department Contact:			
NPI #:	Federal Tax ID #:		Professional Lic. #:

Payment Agreement

Check the payment method you would like to establish

- Patient Prepay only -- make me a non-billable account
- I will send payment in full with each test submission
- Bill physician account. I agree to pay all balances not paid as above within 30 days of the statement date. I understand that, if I do not pay such balances within 30 days, the balance will be charged to my credit card. **When "Bill Physician" is selected on the Test Requisition Form, I agree to be financially responsible for payment of laboratory testing that is requested from Metamatrix.**

Signature Required:

- I authorize Metamatrix to charge all balances to my credit or debit card at month's end.

If you would like to charge services to a credit card account you may leave your credit card information on file by completing the information below. Please indicate on each Test Requisition Form that you would like to bill credit card on file.

Card Type:	<input type="checkbox"/> MasterCard	<input type="checkbox"/> Visa	<input type="checkbox"/> American Express	<input type="checkbox"/> Discover
Card #:	Card Security Code (CSC):		Exp. Date:	
Name on Card:				
Signature:				

I understand that the Metamatrix Application Specialists' role is to inform healthcare professionals of potential applications of test results and not to make specific recommendations of products or dosages for any specific patient.

I hereby confirm that I, _____, meet all state license requirements and have authorization to order clinical laboratory testing.

Date: _____



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