Revised Date: _____

P: (214) 382-9960
F: (972) 637-8660
www.cabotlab.com
Lab Director: Pejman Rahimian, PhD, HCLD (ABB), MLS (ASCP)
CLIA ID# 37D2057496

NewClient Information Form (NCI)

Pleasecompleteandsendtoclientservices@cabotlab.com

Facility Information

Facility Name: _____ Facility NPI #: _____ Date: _____

Street Address: _____ Suite: _____ City: _____

State: _____ Zip: _____ County: _____ Phone: _____

Fax: _____ Facility Website: _____ Facility Specialty: _____

Facility Email Address: _____ Client Bill: ☐ Yes ☐ No

Facility Hours Operations: Mon: _____ to _____ Tues: _____ to _____ Wed: _____ to _____

Thurs: _____ to _____ Fri: _____ to _____ Sat: _____ to _____ Sun: _____ to _____

Account Information

Report Account Preferences Delivery Method: (must choose one)

☐ Client Web Portal ☐ Fax: _____ ☐ Email: _____

(For Email Report Delivery, the result report will be a PDF attachment.

If Client Web Portal was selected , designate your Portal user(s) below:

First Name: _____ Last Name: _____ Title: _____

Email: _____ Phone No: _____ Ext: _____

First Name: _____ Last Name: _____ Title: _____

Email: _____ Phone No: _____ Ext: _____

First Name: _____ Last Name: _____ Title: _____

Email: _____ Phone No: _____ Ext: _____

Contact Information

Facility Contact Information:

First Name: _____ Last Name: _____ Title: _____

Email: _____ Phone No: _____ Ext: _____

Billing Contact Information:

First Name: _____ Last Name: _____ Title: _____

Email: _____ Phone No: _____ Ext: _____

After Hours & Critical Values Contact (Mandatory Information for Infectious Disease Testing Only)

First Name: _____ Last Name: _____

Title: _____ Email: _____

Phone No: _____ Ext: _____ Fax: _____

*Only for the purpose of reporting critical test results or requesting critical required specimen information that has not been provided. The contact provided must either be the clinical decision maker or have 24/7 access to that person to prevent potential delay in patient care.

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Shipping Information

Shipping Method: ☐ FedEx ☐ Courier ☐ Not Required

FedEx Pick up times: M-F 10 AM - 5 PM
Courier Pick up times: M-F 2 PM - 4:30 PM

FedEx Shipping Pick Up Schedule: Please provide a 4-hour window for each day you would like your specimens picked up by FedEx.

Monday: _____ AM/PM to _____ AM/PM

Tuesday: _____ AM/PM to _____ AM/PM

Wednesday: _____ AM/PM to _____ AM/PM

Thursday: _____ AM/PM to _____ AM/PM

Friday: _____ AM/PM to _____ AM/PM

Please add any shipping/supply directions for client services below:

_____

_____

_____

_____

_____

_____

Additional Account Information

Estimated Start Date: _____

Estimated Payor Mix: Medicare: _____% Medicaid: _____% Private: _____% Client Bill: _____% Self-Pay: _____**%**

Estimated Infectious Disease Monthly Samples: Core Infectious Disease: _____ COVID: _____

Infectious Disease: ☐ UTI ☐ STI ☐ BV/AV ☐ Women's Health ☐ Wound ☐ RPP ☐ Covid ☐ GI ☐ Nail

NGS: ☐ Primary Immunodeficiency Panel ☐ Hereditary Neurology Risk Panel ☐ Cardio-pulmonary combined ☐ CancerGenomics Panel (CGX)

☐ Thyroid Risk Panel ☐ Eye Disorders Risk Panel ☐ PharmacoGenomics (PGx)

Initial Supplies Delivered to: ☐ Account Address ☐ Other Address: _____

☐ Pickup at Cabot: Date: _____ Time: _____

*Pickup only available Monday-Friday from 10am-3pm

Please add any additional note for client services below:

_____

_____

_____

_____

_____

_____

_____

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Test Orders: Provider Signature Log, E-Signature, and Equipment Authorization

As a provider, I acknowledge that I am authorized to order laboratory tests. I understand that Cabot Lab, LLC ("Cabot Lab") requires each lab requisition or order submitted to be signed by a provider and that each signature must be a legible, handwritten, full signature with credentials, handwritten initials, or electronic signature. Stamped signatures are not acceptable. Documentation with initials or illegible signatures must include a signature log with a typed or printed name, credentials, and a sample of the signature and initials.

Additionally, I acknowledge and authorize that my signature below may be used by Cabot Lab as my electronic signature for electronic test orders through the Client Web Portal or other electronic ordering platforms, such as electronic medical records, as necessary, for all future orders and any previous orders. Further, to the extent that any paper requisition/test orders are or were submitted without the required legible, handwritten, full signature with credentials, I authorize the past, present, and future reliance on and use of my signature below to support Cabot Lab performing the tests listed on these requisitions/orders.

By way of my signature below, I approve Client Web Portal access to individuals listed under account information and I acknowledge receipt of the equipment and accessories provided by Cabot Lab. I understand and agree that the equipment and accessories provided shall be utilized by the Practice solely and exclusively in connection with Cabot Lab laboratory testing and services only. I also agree that the equipment and accessories shall be kept and used at the location assigned by Cabot Lab and will not be transferred, moved to, or utilized by another establishment.

I understand that any electronic equipment provided may require appropriate safeguards, and I agree to implement such administrative, physical, or technical safeguards, as necessary, to comply with HIPAA and HITECH. I further agree to immediately notify Cabot Lab of any loss, theft, or damage to any equipment or accessories issued by Cabot Lab by contacting Client Services at 214-382-9960 or clientservices@cabotlab.com.

I also acknowledge that Cabot Lab shall always retain ownership of the equipment and accessories. I agree to exercise due care concerning the equipment and accessories and will use my best efforts to safeguard the equipment and accessories from damage, destruction, or misuse. I understand that the electronic equipment and all original accessories, components, and attachments shall be returned in good operating condition.

Electronic signatures for test ordering: (Stamp or electronic signatures are not acceptable. Handwritten/Wet Signatures are required.)

Clinician Signature: { } Clinician Initials (if used for signature): ______________

Clinician Name: ______________________________ Date: ______________________

Credentials: ______________________ Clinician Email: ______________________________

Clinician NPI: ____________________ Clinician Clinic/Group: ______________________________

Clinician Signature: { } Clinician Initials (if used for signature): ______________

Clinician Name: ______________________________ Date: ______________________

Credentials: ______________________ Clinician Email: ______________________________

Clinician NPI: ____________________ Clinician Clinic/Group: ______________________________

Clinician Signature: { } Clinician Initials (if used for signature): ______________

Clinician Name: ______________________________ Date: ______________________

Credentials: ______________________ Clinician Email: ______________________________

Clinician NPI: ____________________ Clinician Clinic/Group: ______________________________

Clinician Signature: { } Clinician Initials (if used for signature): ______________

Clinician Name: ______________________________ Date: ______________________

Credentials: ______________________ Clinician Email: ______________________________

Clinician NPI: ____________________ Clinician Clinic/Group: ______________________________