



Account Agreement – Canada & U.S.A excluding New York State
PLEASE PRINT CLEARLY

| | | | |
|--|-------------------------|--------------------------|----------|
| Practitioner Name: <i>(first)</i> _____ <i>(last)</i> _____ | | Professional Degree: | |
| NPI#: | Professional License #: | State License Issued: | |
| Clinic Name: | | | |
| E-mail: | | | |
| Address: | | | |
| City/Town: | State/Province: | Zip/Postal Code: | Country: |
| Phone #: | | Fax #: | |
| Accounts Payable Dept. Contact: | | Accounts Payable E-mail: | |

Test Report Delivery
Please mark your preferred report delivery method(s) – check all that apply

| | | | |
|--------------------------------------|------------------------------|--|---------------------------------|
| <input type="checkbox"/> U.S. Postal | <input type="checkbox"/> Fax | <input type="checkbox"/> E-mail (if different from above: _____) | <input type="checkbox"/> Online |
|--------------------------------------|------------------------------|--|---------------------------------|

Payment Agreement
Please mark your preferred payment terms

| | |
|--|--|
| <input type="checkbox"/> Prepay with credit card on file for each transaction. | |
| <input type="checkbox"/> I request for US BioTek Laboratories to charge outstanding balances to my credit or debit card monthly. | |
| Card #: _____ | Exp. Date: _____ |
| Name on Card: _____ | Signature: _____ |
| <input type="checkbox"/> Patient prepay only | <input type="checkbox"/> I will send payment in full with each specimen sent for testing by providing a check or credit card number. |
| <input type="checkbox"/> Bill physician account. I am responsible for all balances not paid as above within 30 days of the statement date. I understand that US BioTek Laboratories reserves the right to assign credit limits, and hold testing for clients unable to maintain good payment status. | |
| Practitioner Signature: _____ | |

| | |
|--|--|
| Please tell us how you heard about US BioTek Laboratories | |
| <input type="checkbox"/> Colleague (indicate name): _____ | |
| <input type="checkbox"/> Conference/Seminar (indicate name): _____ | |
| <input type="checkbox"/> Patient | <input type="checkbox"/> Online Search |

| | |
|--|--|
| I understand that I am responsible for the interpretation of all US BioTek Laboratories test reports for my patients, and that I will use my clinical judgment based on my patient's history, symptoms and physical exam findings. | |
| I, _____ certify that I meet all state/province license requirements and I am authorized to order clinical laboratory testing. | |
| Date: _____ | |