



**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
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**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: _____	