



6061 NE 14th Avenue, Fort Lauderdale, FL 33334
Phone: 954-800-1000 | Fax: 954-800-1111
www.firstchoicelaboratory.com

New Account Set-Up Form

Account Sales Rep Information:

Rep Group:	Sales Rep Phone Number:
Sales Rep Name:	Sales Rep Fax Number:
Sales Rep Address:	Sales Rep Email:

Account Information:

Physician/Group Practice			Office Manager Name:
Address:			Office Manager Phone Number:
Address:			Billing Contact Name:
City:	State:	Zip:	Billing Contact Phone Number:
Phone Number:			Office Hours:
Fax Number:			EMR Provider:

Physician Information:

Physician Name:	Specialty:	LIC#:	NPI#:	PECOS: Y/N
1)				<input type="checkbox"/> Y <input type="checkbox"/> N
2)				<input type="checkbox"/> Y <input type="checkbox"/> N
3)				<input type="checkbox"/> Y <input type="checkbox"/> N

Account tests to be administered:

<input type="checkbox"/> Drug Testing <input type="checkbox"/> Saliva <input type="checkbox"/> Urine	<input type="checkbox"/> DNA Testing <input type="checkbox"/> Saliva	<input type="checkbox"/> BLOOD <input type="checkbox"/> WELLNESS <input type="checkbox"/> ALLERGY	<input type="checkbox"/> OTHER TESTING _____
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Account FedEx Pickup and Reporting

Please specify if the Physician/Group Practice needs a regular FedEx pickup day(s) scheduled or if regular pickups are already occurring.		<input type="checkbox"/> Not Needed <input type="checkbox"/> Daily (M-F) <input type="checkbox"/> Mon <input type="checkbox"/> Tue <input type="checkbox"/> Wed <input type="checkbox"/> Thur <input type="checkbox"/> Fri (Please select day(s) required)
Report Preference (Check all that apply): <input type="checkbox"/> Report Portal <input type="checkbox"/> Mail <input type="checkbox"/> Fax-HIPAA Compliant		
The following person should be an employee of the Physician/Group Practice that will manage the report portal for the account.		
Report Portal Contact Name:	Report Portal Contact Phone:	Report Portal Contact Email:

By signing below, I authorize First Choice Laboratory to send patient lab result reports to the person above using the report preference method selected above.

Office Manager/Physician	Print Name:	
Office Manager/Physician	Signature:	Date: