ALLETESS
MEDICAL LABORATORY

Account Agreement | International

PLEASE PRINT CLEARLY

Practitioner Last Name:	Practitioner First Name:	Professional Degree under which you are Authorized to order Clinical Laboratory Testing:	
Professional License#:			
Clinic Name:	Company Name:		
Email:	Email for Result Delivery:		
Phone#:	Fax#:		
Address:			
City/Town:	State/Province:	Zip/Postal Code:	Country:
Accounts Payable Dept. Contact:	Accounts Payable Phone:	Accounts Payable Email:	

I confirm that I, _____, meet all licensure requirements and am authorized to order clinical laboratory testing.

Signature: _____ Date: _____

TEST RESULT WILL BE DELIVERED VIA EMAIL

PAYMENT TERMS

Please choose ONE preferred payment option

❑ **Patient Prepay Only**

Patient will submit payment at time of service

❑ **I request that Alletess Medical Laboratory charge outstanding balances to my credit or debit card monthly**

Mastercard, Visa or Discover. Your credit card will be charged per patient for the first 30 days to establish credit.

Card #:	
Name on Card:	Exp. Date:
Signature:	

PLEASE TELL US HOW YOU HEARD ABOUT ALLETESS MEDICAL LABORATORY

❑ Colleague ❑ Online Search

❑ Patient ❑ Conference/Seminar _____

Details of Conference/Seminar or Referring Colleague

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