



PLEASE PRINT CLEARLY

Practitioner Last Name:		Practitioner First Name:		Professional Degree:	
NPI#:		Professional License#:		State License Issued:	
Clinic Name:					
Email:		Phone:		Fax:	
Address:					
City/Town:			State:	Zip/Postal Code:	Country:
Accounts Payable Dept. Contact:		Accounts Payable Phone:		Accounts Payable Email:	

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

Signature: _____ Date: _____

SUPPLIES NEEDED:

_____ Serum

_____ Fingerstick

TEST RESULT DELIVERY

Please choose ONE preferred delivery option

Email Only

USPS Only

Results with Wellness Plan are sent Fedex Ground

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 ALLETES MEDICAL LABORATORY?

Colleague

Online Search

Patient

Conference/Seminar

_____ Details of Conference/Seminar or Referring Colleague