



ALLETSS MEDICAL LABORATORY

CLIA #22D0080258 / Medicare #22-8226

14 Howard Street, Rockland, MA 02370

PHONE: 781.871.4426 FAX: 781.871.4182 | www.foodallergy.com

ACCOUNT AGREEMENT | CANADA AND U.S.A. (EXCLUDING NEW YORK)

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: _____

Complimentary Test Kits Requested:

- Serum: 2 4
- Fingerstick: 2 4

Additional test kits can be ordered through the clinicians portal on our website, www.foodallergy.com, or by fax or phone.

Test Result Delivery:

Clients can access test results through Sharefile, a secure, cloud-based, HIPPA compliant platform.

Wellness Plan Delivery:

- Hard Copy
- or*
- Electronic PDF

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 when the first sample is received to establish credit.

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

Please tell us how you heard of Alletess Medical Laboratory:

- Colleague
- Online Search
- Patient
- Conference/Seminar _____

Details of Conference/Seminar or referring colleague