New Client Information Form

Please complete and mail to: *account.specialist@healthtrackrx.com*

HEALTH TRACK

Facility Information

Facility Name				Date of Registration			
Reference Lab				Facility Email			
Street		Suite		City		State	Zip
Phone 1		Phone 2		Fax			
Sample Type				Facility Specialty			
Foreign Barcode	☐ Yes ☐ No	Ordering	☐ CWP (Online Portal) ☐ Interface				

After Hours & Critical Values Contact (Mandatory Information for Infectious Disease Testing Only)

After Hours Contact Name / Title					
Email		Mobile Phone		Fax	

* Only for the purpose of reporting critical test results or requesting critical required specimen information that has not been provided. The contact provided must either be the clinical decision maker or have 24/7 access to that person to prevent potential delay in patient care.

Account Preferences

Report Delivery Method (must choose one) ***additional paperwork required***

☐ CWP (Online Portal) ☐ Fax ☐ File Drop* (sFTP) ☐ Interface ☐ Email (password required) Password _____

If selecting Online Portal, designate your Client Web Portal user(s). ***(Select the checkbox to receive email notification when a lab report is ready)***

First Name		Last Name		Email	
First Name		Last Name		Email	

Specimen Pickup Schedule: Call lab as needed or recurring ***(select days / times below)***

Sun	Mon	Tue	Wed	Thu	Fri	Sat	UPS Placard	UPS Placard Size	Sample Pick-Up Area
☐ AM	☐ AM	☐ AM	☐ AM	☐ AM	☐ AM	☐ AM	☐ FedEx	☐ Large (8" x 10")	☐ Front Desk ☐ Lockbox
☐ PM	☐ PM	☐ PM	☐ PM	☐ PM	☐ PM	☐ PM	☐ Courier	☐ Small (4" x 6")	☐ Back Door

Logistics Contact

First and Last Name		Phone Number	

Additional Account Information

Estimated Payor Mix:

Medicare: _____ %

Medicaid: _____ %

Private: _____ %

Client Bill: _____ %

Self-Pay: _____ %

ID Monthly Sample Volume:

CoreId: _____ COVID: _____

Estimated Start Date: _____

Initial Supplies Delivered To:

☐ Rep ☐ Account

☐ Other: _____

Infectious Disease ONEKits Requested:

☐ Thick ☐ Thin

Patient Web Portal Preferences Infectious Disease

Show Positive Results

☐ Yes ☐ No

Notify Patient:

☐ Text ☐ Email ☐ Both

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Test Orders: Provider Signature Log, E-Signature, & Equipment Authorization

- As a provider, I acknowledge that I am authorized to order laboratory tests as supported by medical necessity for treatment purposes. I understand that HealthTrackRx requires each lab requisition or order submitted to be signed by the ordering provider and that each signature must be a legible, handwritten, full signature with credentials, handwritten initials, or, alternatively, an electronic signature. I acknowledge that stamped signatures are not acceptable and that documentation with initials or illegible signatures must include a signature log with a typed or printed name, credentials and a sample of the signature and initials.
- Additionally, I acknowledge and authorize that my signature below may be used by HealthTrackRx as my electronic signature for electronic test orders through the Client Web Portal or other electronic ordering platform such as electronic medical records, as necessary, for all future orders. Further, I agree to document my intent to order the specific test or tests in my signed progress or chart note and to cooperate with HealthTrackRx if it requests a copy of these records or a provider signature attestation.
- As indicated by my signature below, I acknowledge receipt of equipment and accessories provided by HealthTrackRx. I understand and agree that the equipment and accessories provided shall be utilized by the Practice solely and exclusively in connection with HealthTrackRx laboratory testing and services only. Additionally, I also understand and agree that the equipment and accessories shall be kept and used at the location assigned by HealthTrackRx and will not be transferred, moved to, or utilized by another location.
- I understand any electronic equipment provided may require appropriate safeguards, and I agree to implement such administrative, physical, or technical safeguards, as necessary, to comply with HIPAA and HITECH. I further agree to immediately notify HealthTrackRx of any loss, theft, or damage to any equipment or accessories issued by HealthTrackRx by contacting Customer Care at 866-287-3218 or account.specialist@healthtrackrx.com.
- I also acknowledge that HealthTrackRx always retains ownership of the equipment and accessories. I agree to exercise due care with respect to the use of the equipment and accessories and will use best efforts to safeguard the equipment and accessories from damage, destruction, or misuse. I understand the electronic equipment, along with all original accessories, components, and attachments, shall be returned in good operating condition.

EMR Access Acknowledgement

- By use of our services and your signature above, you acknowledge and agree to the following: To ensure your patients' accounts are correctly processed for laboratory services provided and that HealthTrackRx has the necessary information for administrative and operational purposes to provide test results to you, we request limited or "view only" access to your EMR. You agree that individual user IDs may be granted or a single shared user ID for HealthTrackRx staff, in accordance with your organizational access control and information security policies.
- Providing this access will allow our team to (1) view HealthTrackRx requisitions and orders and, where applicable, enter the order from the EMR into HealthTrackRx's Client Web Portal ("CWP"); (2) upload HealthTrackRx PDF test results and reports into the patient's chart; and (3) review a patient's record to obtain patient demographics, insurance information, or other information that is necessary for billing, and (4) medical records/progress notes associated with HealthTrackRx's services.
- You acknowledge that the ordering provider or his/her duly authorized delegate will review and acknowledge all orders in the CWP prior to the submission of any order.
- HealthTrackRx is a Covered Entity under the Health Insurance Portability and Accountability Act ("HIPAA") and will only gather and use protected health information for the purposes described above which are related to treatment and payment. Please see our Privacy Policy for additional details about how we protect patient information (https://www.healthtrackrx.com/privacy-statement/).

Clinician Signature: _____

Clinician Initials (if used for signature): _____

Clinician Name (print): _____ Date: _____

Credentials: _____ Clinician Email: _____

Clinician NPI: _____ Clinician Clinic / Group: _____

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Clinician Signature: ______________________________

Clinician Initials (if used for signature): ______________

Clinician Name (print): ______________________ Date: ______________

Credentials: ______________________ Clinician Email: ______________

Clinician NPI: ______________________ Clinician Clinic / Group: ______________

Clinician Signature: ______________________________

Clinician Initials (if used for signature): ______________

Clinician Name (print): ______________________ Date: ______________

Credentials: ______________________ Clinician Email: ______________

Clinician NPI: ______________________ Clinician Clinic / Group: ______________

Clinician Signature: ______________________________

Clinician Initials (if used for signature): ______________

Clinician Name (print): ______________________ Date: ______________

Credentials: ______________________ Clinician Email: ______________

Clinician NPI: ______________________ Clinician Clinic / Group: ______________

Clinician Signature: ______________________________

Clinician Initials (if used for signature): ______________

Clinician Name (print): ______________________ Date: ______________

Credentials: ______________________ Clinician Email: ______________

Clinician NPI: ______________________ Clinician Clinic / Group: ______________

Customer Care: 866-287-3218
client.relations@HealthTrackRx.com