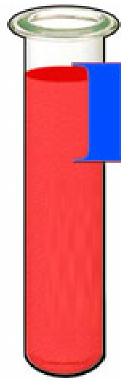

Discount Labwork.com

We help Doctors make MORE money by paying LESS!

Better Services - Better Prices - Better Support

Discount Lab Work

New Customer

Setup Packet

Instructions

1. **Fill out the New Customer Packet**
2. **Print out the completed packet**
3. **Sign completed packet**
4. **Fax to 480-767-6052**

Allow two weeks for account setup and requisite forms.

Sub-Account Information Sheet

All of the information requested below is required to set up a new sub account for an existing NCTS client.

Account Set up Information:

Account Name	
Attn	
Address	
City, State Zip	
Phone	
Fax	
Rep Name and Sales ID	Stephanie Buchler
Ordering Physician (Name, License Number and State, UPIN Number)	
National ID Code	NIDS
Ordering Physician NPI	
If existing accounts are group billed, what is the Group Bill Number?	

Billing Information:

(Bill to the following statement address, complete only if different from information above)

Bill To Name	Discount Labwork
Attn	Dr. Robert Menner
Address City, State Zip	15029 North Thompson Peak Pkwy Building 111 Ste 405 Scottsdale, Arizona 85260
Phone	602-557-2720

Reporting Options:

Final Reports or Partial Reports –

Fax Final (faxed report only, no mailed copy) –
Care360 – LO&R or Physician Portal

The Secure Fax letter must be filled out for either option, signed and faxed to Quest Diagnostics.
If Care 360, user request forms must be completed and authorized by ordering physician.

All information must be complete before submitting.
Email completed form to scottsdaledoc@bloodID.com or fax to 480-767-6052

What Custom Panels (if any) are to be activated for this account?

Use Account #

Dear Client:

Please fill in the areas below in blue and fax this signed letter back to Intelligent Designs, LLC

FAX #: 480-767-6052

You have requested that test results be transmitted to your office by facsimile. Quest Diagnostics is pleased to offer this facsimile reporting service to you. If you agree to the guidelines as explained in this communication, we will be able to begin transmitting once you have completed this form and returned it to us.

Because we are transferring confidential patient medical information in the facsimile transmissions, we ask that you verify that your receiving fax machine is in a secure location. We also require you to verify your fax number. If your fax machine prints on paper that may fade over time, you should make a copy of the faxed report to ensure longevity of the test report. Please provide the information requested below and fax this form to Quest Diagnostics at the number listed at the bottom of this letter.

Return of this letter by you constitutes your representation that the facsimile machine identified below for receiving the electronic transmission of your patients' test results is in a non-public and confidential area. You agree to advise Quest Diagnostics prior to changing your facsimile number. As the Client, you are solely responsible for transmissions of your patients' test results to fax numbers that were changed without prior notice to Quest Diagnostics. The signer of this document represents that he/she has the authority to sign this document on behalf of the Client, and acknowledges that Client is responsible for maintaining the security and confidentiality of the reports sent to the Telephone Number listed below.

Reporting Time(s) for Faxing:
Days of week: ☐Sunday ☐Monday ☐Tuesday ☐Wednesday ☐Thursday ☐Friday ☐Saturday

Check here if fax is available 7 days / 24 hours _ALL☐_

Reporting Times: Fax As Final

If not completed, the default setting is Mon-Fri: 10am and 4pm (EST)

<u>**Please set up as Fax Final in labs where available**</u>

Account Name: **Intelligent Designs –** ________________________

Account Number: (will be assigned by Quest Diagnostics) __________________

Address where Fax is located:

Authorized Fax Phone Number: ________________________

Effective Date: __________________________

Authorized Contact: ____________________ **Contact Phone** _________________________

Physician (Authorized) Signature: ______________________ **Date:** ____________________

Care360 User Request Setup Form (Sub Account)

All Information is Required

[ ] LO&R (one account/one lab)
[ ] Physician Portal (multiple accounts and/or multiple labs – single sign on)

[X] NEW **[ ] ADD** **[ ] DELETE**

Sales Rep Name and Phone	STEPHANIE BUCHLER / 610.454.6411
Primary Account Number and Lab	TBD
User Name (Last, First)	
User's email Address	
User's Work Phone	

Additional Account Number(s) with Lab(s) that User is Authorized to access:

Authorization for Viewing:
Dr.RobertMenner
DiscountLabWork

Email completed forms to scottsdaledoc@bloodID.com or fax to 480-767-6052

Date Submitted:

****
For ES Contracts Use Only

Ordering Options Requested for user: NoOrders
Reporting Options Requested for user: Reports/Cumulative/Statistics

____
Dr. Garrett
Medical Director
Discount Labwork

Quest Diagnostics

CLIENT NAME & ADDRESS:

CLIENT SUPPLY ORDER FORM

TO BE COMPLETED ONLY IF CLIENT WILL BE DRAWING BLOOD IN THEIR OFFICE

QTN.	UNIT	ITEM #	DESCRIPTION	QTN.	UNIT	ITEM #	DESCRIPTION
			VACUTAINER TUBES				CYTOLOGY SUPPLIES
	EACH	38417	LT. BLUE TOP 3.2 % 4.5 ml		25/tray	11055	THIN PREP PAP KITS (w/brush)
	EACH	130057	GREY TOP 4 ml		25/tray	11052	THIN PREP PAP KITS (w/brooms)
	EACH	128025	GREEN TOP w/sodium heparin 4 ml		25/box	50176	PAP PAK KIT W/BRUSH
	EACH	53697	GREEN TOP w/lithium heparin 5 ml		25/tray	129731	SUREPATH w/broom
	EACH	64317	GREEN TOP w/sodium heparin 10 ml		25/tray	133062	SUREPATH w/ brush & spatula
	PK/100	125753	LAVENDER TOP 4 ml		EACH	3113	HPV KITS
	PK/100	53712	RED TOP 10 ml		100/bx	50171	CYTOLOGY BRUSHES
	PK/100	41714	SERUM SEPERATOR 7.5 ml		EACH	48905	CYTO JARS (urine cytology)
					36/PK	118201	CARDBOARD SLIDE HOLDERS
			SPECIALTY TUBES		EACH	119222	CYTOLOGY FIXATIVE
	EACH	38416	ROYAL BLUE TOP w/ HEPARIN		72/PK	104719	FROSTED CYTOLOGY SLIDES
	EACH	38427	ROYAL BLUE TOP NO ADDITIVE		100/pk	117420	PLASTIC SCRAPERS
	EACH	113306	ROYAL BLUE TOP EDTA TRACE				MICROBIOLOGY SUPPLIES
	EACH	50893	WHITE TOP PPT EDTA		EACH	3184	SWAB-RED CAP (aerobic culture)
	EACH	53719	YELLOW TOP ACD SOLUTION A		EACH	132749	SWAB-BLUE CAP (routine wound)
	EACH	2617	PTH-RP TRANSPORT TUBE		EACH	132763	SWAB-YELLOW CAP (gel mini-tip)
	EACH	53721	YELLOW TOP SPS		EACH	116480	SWAB-GREEN CAP (liquid mini-tip)
					EACH	60104	DOUBLE RED CAP SWAB (strep A)
			URINE CONTAINERS		BX/10	129023	INSURE HEMOCULT COLLECTION
	EACH	133962	URINALYSIS TUBES		EACH	118213	PARA-PAK STOOL CULTURE VIAL
	EACH	131521	URINE CULTURE TUBES		EACH	127610	OVA & PARASITE STOOL KITS
	EACH	130504	STERILE CONTAINERS		EACH	125055	GEN PROBE COLLECTOR (female)
	EACH	100 /slv	URINE CUP (7 OZ)		EACH	125056	GEN PROBE COLLECTOR (male)
	EACH	100 /slv	URINE CUP LIDS		EACH	38793	STOOL CONTAINERS
	18/BAG	20001	BORIC ACID TABLETS		EACH	36340	SPUTUM COLLECTION KIT
	EACH	103357	24 HR URINE JUGS (no preservative)		EACH	56471	BLOOD CULTURE (aerobic)
	EACH	9002776	24 HR URINE JUGS w/ 6N HCL		EACH	113770	BLOOD CULTURE (anaerobic)
______	EACH	63352	24 HR URINE JUGS w/ THYMOL &VAIL		EACH	135792	BD PROBE TEC (FEMALE SWAB)
					EACH	135793	BD PROBE TEC (MALE SWAB)
			NEEDLES		EACH	135909	BD PROBETEC (URINE KIT)
	100/BX	38552	21 x 1				
	100/BX	50925	22 x 1				MISCELLANEOUS
	48/ BX	118200	21 x 1 1/4 safety		100/pk	63278	SPECIMEN BAGS- ROUTINE
	48/ BX	65805	22 x 1 1/4 safety		100/pk	63279	SPECIMEN BAGS - FROZEN
	EACH	132165	VACUTAINER HOLDER (regular)		100 /bg	63106	TRANSFER TUBES
	EACH	65804	PRONTO SAFETY NEEDLE HOLDER		100/ bg	63077	CAPS FOR TRANSFER TUBES
	EACH	37779	TOURNIQUET		EACH	51288	LOCKBOX (standard size)
			PATHOLOGY/MISC.		EACH	51290	LOCKBOX (large size)
	EACH	135744	FORMALIN JAR 20 ml		EACH	51244	LOCKBOX KEY
	EACH	135749	FORMALIN JAR 60ML		EACH	17303	DISPOSABLE PIPETTES
					EACH	9000140	SUPPLY ORDER FORMS
					EACH	9000062	SPECIMEN COLLECTION GUIDE

THESE SUPPLIES ARE PROVIDED ONLY FOR THE USE AND PREPARATION OF SPECIMENS TO BE SENT TO QUEST DIAGNOSTICS.

TERMS OF SERVICE

Discount Labwork ("DISCOUNT LABWORK"), requires payment through VISA, MasterCard, Discover or American Express credit cards. A valid credit card must be kept on file at all times. Please fill out the following credit card authorization agreement, read the terms below and sign.

NAME

ADDRESS

CITY, STATE ZIP

E-MAIL

PHONE FAX

PREFERRED METHOD OF REPORT DELIVERY IS (email, fax, snail mail)

CIRCLE TYPE OF CARD: VISA MASTERCARD DISCOVER AMEX

CC#______________________________________ EXP. DATE_________ SECURITY CODE_______

BILLING ADDRESS FOR CREDIT CARD IF DIFFERENT THAN ABOVE

NAME ____

ADDRESS____

CITY____ STATE_______ ZIP_________

I authorize DISCOUNT LABWORK to keep my signature on file and charge my credit card for every test ordered by me through DISCOUNT LABWORK. Credit card billing takes place at the time lab results are either faxed or e-mailed. An itemized statement of charges will be sent to me at the end of each month. DISCOUNT LABWORK setup fee is $150.00. I understand that **DISCOUNT LABWORK does not accept insurance or file insurance claims** and that I am responsible for all lab tests run on requisition forms assigned to me with my name pre-printed as the ordering physician. **DISCOUNT LABWORK reserves the right to terminate services for any reason**, including, but not limited to, failure to pay, declined or bad credit card on file, failure to follow paperwork protocols, failure to meet terms set forth in this agreement. I also agree to return or destroy all unused requisition forms, which are the property of DISCOUNT LABWORK, to DISCOUNT LABWORK if I decide to terminate my membership. I am putting a copy of my professional license on file for documentation purposes to obtain requisitions and then order laboratory tests for my patients. I further assert that I understand that DISCOUNT LABWORK is ONLY a professional service and all responsibility for my patients is mine. I will obtain all proper authorizations from the patient and that if I do not, I accept all responsibility for this omission and DISCOUNT LABWORK will be held harmless by me. I have read, signed and returned the HIPAA Privacy Business Associate Agreement.

SIGNATURE____ DATE_________

Initial Set up Fee $150.00

Representative Comment: ____

Dr. Robert Menner
National Representative
scottsdaledoc@bloodID.com

Terms of Service Agreement

This Agreement is made effective the ____ of ____, 2008, by and between ,
hereinafter referred to as "Covered Entity", and Discount Labwork hereinafter referred to as "Business Associate", (individually, a "Party" and collectively, the "Parties").

WITNESSETH:

WHEREAS, Sections 261 through 264 of the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, known as "the Administrative Simplification provisions," direct the Department of Health and Human Services to develop standards to protect the security, confidentiality and integrity of health information; and

WHEREAS, pursuant to the Administrative Simplification provisions, the Secretary of Health and Human Services has issued regulations modifying 45 CFR Parts 160 and 164 (the "HIPAA Security and Privacy Rule"); and

WHEREAS, the Parties wish to enter into or have entered into an arrangement whereby Business Associate will provide certain services to Covered Entity, and, pursuant to such arrangement, Business Associate may be considered a "business associate" of Covered Entity as defined in the HIPAA Security and Privacy Rule; and

WHEREAS, Business Associate may have access to Protected Health Information (as defined below) in fulfilling its responsibilities under such arrangement;

THEREFORE, in consideration of the Parties' continuing obligations under the Arrangement Agreement, compliance with the HIPAA Security and Privacy Rule, the receipt and sufficiency of which is hereby acknowledged, the Parties agree to the provisions of this Agreement in order to address the requirements of the HIPAA Security and Privacy Rule and to protect the interests of both Parties.

I. DEFINITIONS

Except as otherwise defined herein, any and all capitalized terms in this Section shall have the definitions set forth in the HIPAA Security and Privacy Rule. In the event of an inconsistency between the provisions of this Agreement and mandatory provisions of the HIPAA Security and Privacy Rule, as amended, the HIPAA Security and Privacy Rule shall control. Where provisions of this Agreement are different than those mandated in the HIPAA Security and Privacy Rule, but are nonetheless permitted by the HIPAA Security and Privacy Rule, the provisions of this Agreement shall control.

The term "Protected Health Information" means individually identifiable health information including, without limitation, all information, data, documentation, and materials, including without limitation, demographic, medical and financial information, that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or with respect to which there

is a reasonable basis to believe the information can be used to identify the individual. "Protected Health Information" includes without limitation "Electronic Protected Health Information" as defined below.

The term "Electronic Protected Health Information" means Protected Health Information which is transmitted by Electronic Media (as defined in the HIPAA Security and Privacy Rule) or maintained in Electronic Media.

Business Associate acknowledges and agrees that all Protected Health Information that is created or received by Covered Entity and disclosed or made available in any form, including paper record, oral communication, audio recording, and electronic display by Covered Entity or its operating units to Business Associate or is created or received by Business Associate on Covered Entity's behalf shall be subject to this Agreement.

II. CONFIDENTIALITY AND SECURITY REQUIREMENTS

(a) Business Associate agrees:

(i) to use or disclose any Protected Health Information solely: (1) for meeting its obligations as set forth in any agreements between the Parties evidencing their business relationship, or (2) as required by applicable law, rule or regulation, or by accrediting or credentialing organization to whom Covered Entity is required to disclose such information or as otherwise permitted under this Agreement, the Arrangement Agreement (if consistent with this Agreement and the HIPAA Security and Privacy Rule), or the HIPAA Security and Privacy Rule, and (3) as would be permitted by the HIPAA Security and Privacy Rule if such use or disclosure were made by Covered Entity;

(ii) at termination of this Agreement, the Arrangement Agreement (or any similar documentation of the business relationship of the Parties), or upon request of Covered Entity, whichever occurs first, if feasible, Business Associate will return or destroy all Protected Health Information received from or created or received by Business Associate on behalf of Covered Entity that Business Associate still maintains in any form and retain no copies of such information, or if such return or destruction is not feasible, Business Associate will extend the protections of this Agreement to the information and limit further uses and disclosures to those purposes that make the return or destruction of the information not feasible; and

(iii) to ensure that its agents, including a subcontractor, to whom it provides Protected Health Information received from or created by Business Associate on behalf of Covered Entity, agrees to the same restrictions and conditions that apply to Business Associate with respect to such information, and agrees to implement reasonable and appropriate safeguards to protect any of such information which is Electronic Protected Health Information. In addition, Business Associate agrees to take reasonable steps to ensure that its employees' actions or omissions do not cause Business Associate to breach the terms of this Agreement.

(b) Notwithstanding the prohibitions set forth in this Agreement, Business Associate may use and disclose Protected Health Information as follows:

(i) if necessary, for the proper management and administration of Business Associate or to carry out the legal responsibilities of Business Associate, provided that as to any such disclosure, the following requirements are met:

(A) the disclosure is required by law; or

(B) Business Associate obtains reasonable assurances from the person to whom the information is disclosed that it will be held confidentially and used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies Business Associate of any instances of which it is aware in which the confidentiality of the information has been breached;

(ii) for data aggregation services, if to be provided by Business Associate for the health care operations of Covered Entity pursuant to any agreements between the Parties evidencing their business relationship. For purposes of this Agreement, data aggregation services means the combining of Protected Health Information by Business Associate with the protected health information received by Business Associate in its capacity as a business

associate of another covered entity, to permit data analyses that relate to the health care operations of the respective covered entities.

(c) Business Associate will implement appropriate safeguards to prevent use or disclosure of Protected Health Information other than as permitted in this Agreement. Business Associate will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of any Electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of Covered Entity as required by the HIPAA Security and Privacy Rule.

(d) The Secretary of Health and Human Services shall have the right to audit Business Associate's records and practices related to use and disclosure of Protected Health Information to ensure Covered Entity's compliance with the terms of the HIPAA Security and Privacy Rule.

(e) Business Associate shall report to Covered Entity any use or disclosure of Protected Health Information which is not in compliance with the terms of this Agreement of which it becomes aware. Business Associate shall report to Covered Entity any Security Incident of which it becomes aware. For purposes of this Agreement, "Security Incident" means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system. In addition, Business Associate agrees to mitigate, to the extent practicable, any harmful effect that is known to Business Associate of a use or disclosure of Protected Health Information by Business Associate in violation of the requirements of this Agreement.

III. AVAILABILITY OF PHI

Business Associate agrees to make available Protected Health Information to the extent and in the manner required by Section 164.524 of the HIPAA Security and Privacy Rule. Business Associate agrees to make Protected Health Information available for amendment and incorporate any amendments to Protected Health Information in accordance with the requirements of Section 164.526 of the HIPAA Security and Privacy Rule. In addition, Business Associate agrees to make Protected Health Information available for purposes of accounting of disclosures, as required by Section 164.528 of the HIPAA Security and Privacy Rule.

IV. TERMINATION

Notwithstanding anything in this Agreement to the contrary, Covered Entity shall have the right to terminate this Agreement and the Arrangement Agreement immediately if Covered Entity determines that Business Associate has violated any material term of this Agreement. If Covered Entity reasonably believes that Business Associate will violate a material term of this Agreement and, where practicable, Covered Entity gives written notice to Business Associate of such belief within a reasonable time after forming such belief, and Business Associate fails to provide adequate written assurances to Covered Entity that it will not breach the cited term of this Agreement within a reasonable period of time given the specific circumstances, but in any event, before the threatened breach is to occur, then Covered Entity shall have the right to terminate this Agreement and the Arrangement Agreement immediately.

V. MISCELLANEOUS

Except as expressly stated herein or the HIPAA Security and Privacy Rule, the parties to this Agreement do not intend to create any rights in any third parties. The obligations of Business Associate under this Section shall survive the expiration, termination, or cancellation of this Agreement, the Arrangement Agreement and/or the business relationship of the parties, and shall continue to bind Business Associate, its agents, employees, contractors, successors, and assigns as set forth herein.

This Agreement may be amended or modified only in a writing signed by the Parties. No Party may assign its respective rights and obligations under this Agreement without the prior written consent of the other Party.

None of the provisions of this Agreement are intended to create, nor will they be deemed to create any relationship between the Parties other than that of independent parties contracting with each other solely for the purposes of effecting the provisions of this Agreement and any other agreements between the Parties evidencing their business relationship. This Agreement will be governed by the laws of the State of South Carolina. No change, waiver or discharge of any liability or obligation hereunder on any one or more occasions shall be deemed a waiver of performance of any continuing or other obligation, or shall prohibit enforcement of any obligation, on any other occasion.

The parties agree that, in the event that any documentation of the arrangement pursuant to which Business Associate provides services to Covered Entity contains provisions relating to the use or disclosure of Protected Health Information which are more restrictive than the provisions of this Agreement, the provisions of the more restrictive documentation will control. The provisions of this Agreement are intended to establish the minimum requirements regarding Business Associate's use and disclosure of Protected Health Information.

In the event that any provision of this Agreement is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions of this Agreement will remain in full force and effect. In addition, in the event a party believes in good faith that any provision of this Agreement fails to comply with the then-current requirements of the HIPAA Security and Privacy Rule, such party shall notify the other party in writing, For a period of up to thirty days, the parties shall address in good faith such concern and amend the terms of this Agreement, if necessary to bring it into compliance. If, after such thirty-day period, the Agreement fails to comply with the HIPAA Security and Privacy Rule, then either party has the right to terminate upon written notice to the other party.

IN WITNESS WHEREOF, the Parties have executed this Agreement as of the day and year written above.

COVERED ENTITY:	BUSINESS ASSOCIATE:
Print Name:________________________	Print Name: **Dr. Robert Menner, President**
Signature: ________________________	Signature:_________________________
Date: ________________________	Date: _________________________

Representative Comment:

Dr. Robert Menner
National Representative
scottsdaledoc@bloodID.com