

NEW CLIENT REGISTRATION FORM Please e-mail completed form to info@veritaslabllc.com

Phone _____ Email _____

CLIENT INFORMATION

Facility Name _____

Address _____ City _____ State _____ Zip _____

Main Contact Name _____ Phone _____

Email _____ Fax _____

Ordering Physician's Full Name _____ Credentials _____

Name Ordering Physician's NPI _____ License # _____

Other Contacts: (EMAIL MUST be filled out receive online portal access)

First Name _____ Last Name _____

Email _____ Phone _____

First Name _____ Last Name _____

Email _____ Phone _____

PAYER MIX

SPECIMEN PICKUP DAYS

Additional providers and locations on page 2 101–

Anticipated Monthly Volume Less than 50 51–100 300 301–500 501 or More

Shipping Method	Courier	Drop-off	FedEx	Pickup time	
Pickup Day(s)	Monday	Tuesday	Wednesday	Thursday	Friday

TEST REPORT DELIVERY METHOD

Online Portal	EMR Interface
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SPECIAL REQUEST(S) OR SUPPLY REQUEST(S)

ADDITIONAL LOCATION(S)

Address for clinic location(s) where orders will be placed and samples will be collected:

Additional Location Address City State Zip

Phone Email Facility

Name (if different from Primary):

Online Portal Log-In Needed Yes No If yes, email MUST be filled out above to receive online portal access

Shipping	Courier	Drop-off	FedEx	Pickup time	
Method Pickup	Monday	Tuesday	Wednesday	Thursday	Friday

Day(s)

Address for clinic location(s) where orders will be placed and samples will be collected:

Additional Location Address City State Zip

Phone Email Facility Name (if different from Primary):

Online Portal Log-In Neede Yes No If yes email MUST be filled out above to receive on line portal access

Shipping	Courier	Drop-off	FedEx	Pickup time	
Method Pickup	Monday	Tuesday	Wednesday	Thursday	Friday

Day(s)

ADDITIONAL PHYSICIANS

Ordering Physician's Full Name

Credentials Ordering Physician's NPI #

Ordering Physician's Full Name

Credentials Ordering Physician's NPI #

PHYSICIAN/PRACTICIONER AGREEMENT

1. I authorize Veritas Laboratory, LLC to perform testing on my patients from my practice as directed by the individual requisition forms as well as my predefined custom profile on file, if applicable. I understand that it is my option to use a predefined custom profile or select specific tests on the test requisition form.
2. By signing this form, it is hereby certified that the treating physician shall review the volume, frequency, and duration of testing and order laboratory testing accordingly and in accordance with clinical indication and medical necessity. I understand that it is my responsibility to determine the medical necessity of tests I have requested for the treatment and/or diagnosis of my patients. I agree to provide diagnosis codes, defined to the highest level of specificity, for each test that I order to confirm medical necessity and to enable Veritas Laboratory, LLC to bill effectively on my patient's behalf.
3. I further understand that according to Medicare, "Confirmation of drug screens is indicated when the result of the drug screen is different than that suggested by the patient's medical history, clinical presentation, or patient's own statement."
4. By signing this form, I acknowledge if any Point of Care (POC) device is provided by the lab I will not directly or indirectly bill or collect a fee for POC testing without submitting payment to the lab for the device at a fair market value rate. I agree and understand the device will be used solely to collect, transport, process, or store specimens referred to the lab for testing. I acknowledge and understand that use of the POC device for any other purpose or billing for POC testing with laboratory-provided POC devices without remitting payment for same to the lab could be interpreted as a violation of AntiKickback Statute 42 U.S. C. § 1320a-7b.
5. I acknowledge if any POC device is provided by the lab and I remunerate off any service in which the device is used, I will receive an invoice and remit payment for the device at fair market value.
6. I understand that the Office of the Inspector General (OIG) has cautioned: "Using a customized profile may result in the ordering of test which are not covered, reasonable or necessary. OIG takes the position that an individual who knowingly causes a false claim to be submitted may be subject to sanctions or remedies available under civil, criminal, and administrative law."
7. I understand that Veritas Laboratory, LLC will be billing third parties for the tests I ordered. I will provide signed written orders for the patient's medical records to the requesting party or Veritas Laboratory, LLC within 72 hours.
8. I verify that I am ordering testing to be performed at Veritas Laboratory, LLC and its affiliated contracted laboratories.
9. My predefined custom profile will be valid for 180 days from the date of signature. I understand I may request changes to my predefined custom profile at any time. The signatories hereto understand there may be applicable National Coverage Determinations and Local Coverage Determinations for clinical laboratory testing.
10. I understand that Veritas Laboratory, LLC reflects the views, recommendations and guidelines outlined in the CMS National Coverage Policy. I acknowledge Veritas Laboratory, LLC has provided me with information regarding its policies and guidelines for laboratory testing to my satisfaction.
11. "I certify that I have authorized the staff of _____ (Facility name) to enter test orders as indicated by me to be medically necessary into the Laboratory Information Management system or _____ (Facility Name) EMR system and will monitor those testing orders on an ongoing basis so ensure only medically necessary tests are being requested according to the individualized treatment plan of each patient under my care that I have outlined in the patient chart
12. I authorize Veritas Laboratory, LLC to upload my signature from the signature box below to the online portal. I acknowledge my signature will be used by the laboratory for all laboratory records and medical records requested by the insurance company. I acknowledge that I can add a signature, update my signature and remove my signature at any time directly on the on line portal.

Physician/Practitioner Name

Physician/Practitioner NPI #

Date

Physician/Practitioner
 Signature (Please sign above for
 signature upload)

PROTECTED HEALTH INFORMATION (PHI) ACCESS AGREEMENT FOR NON-LABORATORY SERVICES USERS

This Agreement is entered into on this ____ day of _____ by and between Veritas Laboratory, LLC and an employee of the following client _____ located at: . WHEREAS, Veritas Laboratory, LLC makes accessible to the following users its Electronic Medical Online Portal, which contains a broad range of electronically stored medical information about patients, doctors and their medical history and results, including Protected Health Information as herein defined. Veritas Laboratory, LLC wishes to allow User to have access to the Electronic Medical Online Portal so that User may access such medical information needed by User to provide healthcare and/or healthcare services for patients; NOW, THEREFORE, in consideration of the mutual promises contained herein, the parties agree as follows:

I. CONDITIONS

In consideration for use of the Electronic Medical Online Portal, User agrees to the following terms and conditions

- a) Will not share or give his/her user or password to any other individual, or will take the appropriate measures to safeguard his/her credentials;
- b) To not use or disclose patient Protected Health Information other than as permitted or as required by law;
- c) To use appropriate safeguards and practices to prevent use or disclosure of the patient Protected Health Information other than as provided for in this Agreement.
- d) If documents are printed for patient care, they should be kept secure while in use and shredded when no longer needed.
- e) Printed documents may not be removed from the healthcare facility unless being given to laboratory to lab results.
- f) The user will log out of the application before leaving the computer for any certain amount of time.
- g) To mitigate, to the extent practicable, any harmful effect that is known to User of a use or disclosure of Protected Health Information in violation of the requirements of this Agreement;
- h) To comply with all applicable federal and state laws and regulations which protect the confidentiality of Protected Health Information;
- i) To not act or fail to act in a way that would cause Veritas Laboratory, LLC to be noncompliant with applicable federal or state laws or regulations which protect the confidentiality of protected health information;
- j) To promptly notify a Veritas Laboratory, LLC when changes occur in his/her practice or job duties which would eliminate or materially affect his/her status or stated justification for access to Electronic Medical Online Portal.
- k) To promptly report to the Veritas Laboratory, LLC of any use or disclosure of Protected Health Information of which he/she

II. TERMS OF ACCESS

User agrees to the following once she/he has access to Electronic Medical Online Portal from Veritas Laboratory, LLC:

- a) Electronic Medical Online Portal access is protected health information only for the sole purpose of retrieving and providing healthcare services
- b) Information, including Protected Health Information, accessed and/or retrieved from the Electronic Medical Online Portal, is intended only for the review and/or use of the authorized user for legitimate medical needs.
- c) User's access to the Electronic Medical Online Portal will be recorded electronically, and Electronic Medical Online Portal access and use will be audited by Veritas Laboratory, LLC at any time on a random basis or for cause
- d) This is agreement is guarantee until the end of the calendar year and must be renew every year or when there is a modification, Veritas Laboratory, LLC will inform all users in writing.

III. TERMINATION

Veritas Laboratory, LLC has the right to immediately terminate this agreement and discontinue access to the Electronic Medical Online Portal at any time for any reason.

IV. INDEMNIFICATION

User shall be responsible for any breach of this agreement, whether by User or by User's agents, representatives, or employees. User shall defend, indemnify, and hold Veritas Laboratory, LLC harmless from all damages, costs, expenses and fees (including attorneys' fees) resulting from such breach.

User First & Last Name

User Signature _____ Date Date Email

Custom Panel Requisition and Authorization Form

Qualitative Presumptive Screen (Immunoassay) (80307)				
AMPHETAMINE	BUPRENORPHINE	FENTANYL	OPIATES	TRAMADOL
BARBITURATES	COCAINE METABOLITE	6-ACETYLMORPHINE	OXYCODONE	METHAMPHETAMINE
BENZODIAZEPINES	ETG	EDDP	CANNABINOIDS	

Qualitative Presumptive Screen

Initial

Quantitative Confirmation Testing

Initial

Validity Testing

CREATININE	SPECIFIC GRAVITY
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Quantitative Confirmation Testing (G0480) (G0481) (G0482) (G0483)

ANTI-DEPRESSANT / INCONTINENT	OPIOID	TRICYCLIC ANTIDEPRESSANTS	MUSCLE RELAXANTS
Duloxetine	6-Acetylmorphine	Amitriptyline	Meprobamate
	6-Beta-Naltrexol	Desipramine	Carisoprodol
ANTIEPILEPTICS	Buprenorphine	Imipramine	OTHERS
Cyclobenzaprine	Codeine	Nortriptyline	Cotinine
Gabapentin	EDDP	BARBITURATE	STIMULANT
Pregabalin	Fentanyl	Butalbital	Amphetamine
ANTIPSYCHOTICS	Hydrocodone	Phenobarbital	Benzoylcegonine
7-Hydroxyquetiapine	Hydromorphone	BENZODIAZEPINE	MDA
9-Hydroxyrisperidone	Meperidine	2-Hydroxyethylflurazepam	MDEA
Dehydroaripiprazole	Morphine	7-Aminoclonazepam	MDMA
ANTITUSSIVE	Norbuprenorphine	7-Aminoflunitrazepam	Mephedrone
Dextropropofol	Norfentanyl	alpha-Hydroxyalprazolam	Methadone
KRATOM	Norhydrocodone	Alprazolam	Methamphetamine
7-Hydroxymitragynine	Normeperidine <input type="checkbox"/>	Lorazepam	Ritalinic Acid
Mitragynine	Noroxycodone	Nordiazepam	THC
OPIOID ANTAGONISTS	O-Desmethyltramadol	Oxazepam	THC-COOH
Naloxone	Oxycodone	Temazepam	Z-DRUG SEDATIVES
Naltrexone	Oxymorphone	HALLUCINOGENS & DISSOCIATIVES	Zolpidem
OTHER ANTIDEPRESSANTS	Propoxyphene	Ketamine	
Doxepin	Tapentadol	Norketamine	
Fluoxetine	Tramadol	PCP	
Hydroxybupropion	SYNTHETIC CANNABINOIDS		
N-desmethylcitalopram	JWH-018 4-Hydroxypentyl		
O-Desmethylvenlafaxine	JWH-073 3-Hydroxybutyl		
Paroxetine	UR-144 5-Hydroxypentyl		
Sertraline	XLR-11 4-Hydroxypentyl		
Trazodone			
Venlafaxine			

ACKNOWLEDGEMENTS

I agree to order this custom panel only when each of the individual tests are medically necessary as documented in the patient's chart. I understand that I have the choice to order any or all drug tests individually at any time, without ordering a customized panel. I also agree to provide diagnosis codes defined to the highest level of specificity, for each test in order to confirm medical necessity and to bill effectively on behalf of the client.

I understand that the Office of Inspector General (OIG) has stated:

"using a customized profile may result in the ordering of tests which are not covered, reasonable or necessary"

"OIG takes the position that an individual who knowingly causes a false claim to be submitted may be subject to sanctions or remedies available under civil, criminal and administrative law."

The Custom panel designated here has been specifically developed and approved by me for my use as ordering provider. I will only request this custom panel to be performed if and when I have determined that each individual test of this profile is medically necessary for the particular patient on the date of service.

Print Name

NPI #

Date

Signature