DOCTOR'S CHOICE™

Professional Laboratory & Diagnostic Services

TERMS OF SERVICE

Doctor's Choice requires payment through Visa, MasterCard, Discover or American Express credit cards. A valid credit card must be on file at all times. Please fill out the following credit card authorization agreement, read the terms below and sign.

NAME _____ DEGREE _____
ADDRESS _____
CITY _____ STATE_____ ZIP _____
E-MAIL _____
PHONE _____ FAX _____

REFERRED BY: Dr. John Brimhall

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 "Doctor's Choice" to keep my signature on file and charge my credit card for every test ordered by me through "Doctor's Choice". Credit card billing takes place at the time lab results are transmitted. You will receive an itemized statement of charges at the end of each month. There is a $300.00 membership fee to join Doctor's Choice. This includes a $250 enrollment fee and the annual membership fee of $50 for the first year. The annual membership renewal fee is $50, payable every 12 months, which will be automatically charged to my credit card unless I notify "Doctor's Choice" in advance of my intent to terminate my membership. I understand that "Doctor's Choice" does not accept insurance nor file insurance claims and that I am responsible for all tests performed on requisition forms assigned to me. I agree to follow all disclosed membership rules and guidelines as well as abide by all state and federal laws as a requirement for maintaining my active membership status with "Doctor's Choice" and if I do not, my membership may be terminated. I also agree to return or destroy all unused requisition forms, which are the property of "Doctor's Choice", to "Doctor's Choice" 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 "Doctor's Choice" 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 "Doctor's Choice" will be held harmless by me. I have read, signed and returned the HIPAA Privacy Business Associate Agreement.

SIGNATURE _____ DATE _____

Please fax all completed & signed forms with a copy of your current license to our office and keep copies for your records. "Doctor's Choice" reserves the right to reject any application. Thank you!