

# Metamatrix Account Agreement

## Confidential Client Information

If you have registered for an account online at [www.metamatrix.com](http://www.metamatrix.com), you do not have to complete the following form. The account verification process may take up to two business days

Clinician Name:	Degree:	Account #:	OFFICE USE ONLY
Specialty:		Date Received:	
Company Name:			
Company Type: (circle one)    Corporation    Partnership    Solo Practice    Individual    Ltd.    Other			
Address:			
City:	State:	Zip:	
Telephone: (    )	Fax: (    )		
E-Mail:			
Bill to Address* (If different than above):			
Accounts Payable Department Contact:			
NPI #:	Federal Tax ID #:	Professional Lic. #:	

## Billing Preference

Please check one default billing preference (Patient Prepay, Clinician Prepay\*, or Bill Clinician\*) you would like to establish for your office. You may change the billing for a specific test on the Test Requisition Form arriving with the specimen collection kit.

Patient Prepay only – make me a non-billable account (Patients will submit payment at time of service)

### Only Option For New York Clinicians

New York State prohibits the billing of clinicians. Patients must prepay only. Acceptable payment methods are indicated below. Please make check or money order payable to Metamatrix, Inc.

Clinician Prepay\* – Clinician will send payment in full with each test submission (May keep credit card on file by entering information below)

\*Not available in New York.

Bill clinician account\*. I understand that my credit card will be charged on the first business day of the new month for all charges in the previous month. As a “bill clinician account”, you must keep a credit card on file. **When “Bill Clinician” is selected on the Test Requisition Form, I agree to be personally, financially responsible for payment of all charges associated with this account.** \*Not available in New York.

Signature Required: \_\_\_\_\_

To charge services to a credit card account you must leave your credit card information on file by completing the information below. Please indicate on each Test Requisition Form that you would like to bill clinician account.

Card Type: (Check one)     MasterCard     Visa     American Express     Discover

Card #: \_\_\_\_\_ Exp. Date: \_\_\_\_\_

Name on Card: \_\_\_\_\_

Signature: \_\_\_\_\_

I understand that the Metamatrix Technical Support Specialists' role is to provide guidelines, information, and education on test results. It is my responsibility, as the healthcare provider, to make treatment recommendations for any specific patient. \_\_\_\_\_

INITIALS

I hereby confirm that I, \_\_\_\_\_, meet all state license requirements and have authorization to order clinical laboratory testing.

CLINICIAN'S NAME (PRINT)

**If you do not meet all the state license regulations, please see the reverse side of this document for account completion.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



3425 Corporate Way, Duluth, Ga 30096  
800.221.4640 • Fax: 770.441.2237 • [www.metamatrix.com](http://www.metamatrix.com)

# ORDERING CLINICIAN INFORMATION

## Confidential Client Information

If you do not meet state licencing regulations to order testing, you must have an ordering clinician that is authorized to order clinical laboratory testing listed on your behalf.  
The account verification process may take up to two business days

I hereby affirm that I am the ordering clinician responsible for \_\_\_\_\_.  
CLINICIAN'S NAME (PRINT)

I understand that my name will appear on patient records as the ordering clinician.

Clinician Name:	Degree:	Account #:	<small>OFFICE USE ONLY</small>
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Specialty:	Date Received:
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Company Name:

Company Type: (check one)     Corporation     Partnership     Solo Practice     Individual     Ltd.     Other

Address:

City:	State:	Zip:
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Telephone: (    )	Fax: (    )
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NPI #:	Federal Tax ID #:	Professional Lic. #:
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I understand that the Metamatrix Technical Support Specialists' role is to provide guidelines, information, and education on test results. It is my responsibility, as the healthcare provider, to make treatment recommendations for any specific patient. \_\_\_\_\_  
INITIALS

I hereby confirm that I, \_\_\_\_\_, meet all state license requirements and have  
CLINICIAN'S NAME (PRINT)  
authorization to order clinical laboratory testing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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