NEW CLIENT ONBOARDING

FILL AND FAX **727-233-1190**

Email eric@products4doctors/com

Main Clinic Information

Clinic Specialty:

☐ Internal ☐ Family ☐ Gastro ☐ OB/GYN

☐ Orthopedic ☐ Pain Mgmt. ☐ Wellness ☐ Other: _____

Clinic Name: _____

Street Address: _____ Suite No. _____

City: _____ State: _____ Zip Code: _____

Office #: _____ Fax #: _____ After Hours #: _____

Main Office Information

Office Manager: _____ Contact #: _____

Contact E-mail: _____

Specimen Collector: _____ Contact #: _____

Contact E-mail: _____

Shipment Handler: _____ Contact #: _____

Contact E-mail: _____

Requested Lab Services

☐ Blood ☐ Drug Tox ☐ GI ☐ RPP

☐ Urinalysis ☐ UTI ☐ Wound ☐ Other: _____

Proximity Lab Services

Contact Eric Karukin Call or Text 727-645-7774 email Eric#products4doctors.com

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Clinic Monthly Averages

Patients	_____	Blood Draws	_____	Wellness Panels	_____
Urinalysis	_____	Tox	_____		

Clinic Insurance Percentages

Commercial	_____	Medicare	_____	Medicaid	_____
Tricare	_____	Worker's Comp	_____	Out of Pocket	_____

Corporate Information

Corporation Name: _____

Street Address: _____ Suite No. _____

City: _____ State: _____ Zip Code: _____

Company Signatory: _____ Contact #: _____

Contact E-mail: _____

EIN: _____

Sales Representative Checklist

- ☐ Provide the new client with a supplies list.
- ☐ Collect $3,500 for CLIA and setup fees.
- ☐ Collect $1,100 for CAP proficiency fees.
- ☐ Obtain all completed intake forms from the new client.
- ☐ Obtain practitioners' signatures and practice logo.

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Please provide all information below regarding practitioners.

Practitioners

First Name: ____________________ Last Name: ____________________ Suffix: __________

Gender: ☐ Male ☐ Female ☐ Not Listed Work Location(s): _________________________

Contact #: _____________________ Contact E-mail: ___________________________________

NPI: ____

First Name: ____________________ Last Name: ____________________ Suffix: _________

Gender: ☐ Male ☐ Female ☐ Not Listed Work Location(s): _________________________

Contact #: _____________________ Contact E-mail: ___________________________________

NPI: ____

First Name: ____________________ Last Name: ____________________ Suffix: __________

Gender: ☐ Male ☐ Female ☐ Not Listed Work Location(s): _________________________

Contact #: _____________________ Contact E-mail: ___________________________________

NPI: ____

First Name: ____________________ Last Name: ____________________ Suffix: __________

Gender: ☐ Male ☐ Female ☐ Not Listed Work Location(s): _________________________

Contact #: _____________________ Contact E-mail: ___________________________________

NPI: ____

First Name: ____________________ Last Name: ____________________ Suffix: __________

Gender: ☐ Male ☐ Female ☐ Not Listed Work Location(s): _________________________

Contact #: _____________________ Contact E-mail: ___________________________________

NPI: ____

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Please provide all information below regarding office staff. One form is required per location.

Office Staff

Clinic Location Name: ____

First Name: ________________ Last Name: ________________ Job Title: ___________________

Gender: ☐ Male ☐ Female ☐ Not Listed StratusDX Access: ☐ Yes ☐ No

Contact #: _____________________ Contact E-mail: ___________________________________

First Name: ________________ Last Name: ________________ Job Title: ___________________

Gender: ☐ Male ☐ Female ☐ Not Listed StratusDX Access: ☐ Yes ☐ No

Contact #: _____________________ Contact E-mail: ___________________________________

First Name: ________________ Last Name: ________________ Job Title: ___________________

Gender: ☐ Male ☐ Female ☐ Not Listed StratusDX Access: ☐ Yes ☐ No

Contact #: _____________________ Contact E-mail: ___________________________________

First Name: ________________ Last Name: ________________ Job Title: ___________________

Gender: ☐ Male ☐ Female ☐ Not Listed StratusDX Access: ☐ Yes ☐ No

Contact #: _____________________ Contact E-mail: ___________________________________

First Name: ________________ Last Name: ________________ Job Title: ___________________

Gender: ☐ Male ☐ Female ☐ Not Listed StratusDX Access: ☐ Yes ☐ No

Contact #: _____________________ Contact E-mail: ___________________________________

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NEW CLIENT ONBOARDING

Confidentiality Agreement

Proximity Lab Services, its affiliates, and related organizations, (collectively “PLS”), hereby agree to grant me, the undersigned, access to PLS’s online portal and access to certain medical information and data (“The Portal”), subject to and contingent upon the terms set forth below. In exchange for access, and as a continuing obligation to maintain limited access to The Portal, I, the undersigned, hereby acknowledge and agree to abide by the following terms, conditions and rules:

Confidential Information:

• I acknowledge that I may obtain confidential patient, clinical, and employee-related information, and proprietary information about the business and financial interests of PLS and its business partners, including access to non-public patient and business information of PLS (collectively “Confidential Information’’). Confidential Information also includes, but is not limited to, information concerning patients, participants of benefit plans and programs, protected health information, customers, contractors of PLS, credentialing, peer review, quality review, committee records, salary and compensation information, logon and password information, health information and information related to the operations and internal business affairs of PLS that are not generally available to the public. I understand that I may learn of or have access to some or all of this Confidential Information through PLS's Portal or through my interactions with PLS. I understand that Confidential Information is valuable and sensitive and is protected by law and by PLS's Policy. The intent of these laws and policies is to ensure that Confidential Information remains confidential and will be used only by those with appropriate authority as necessary to accomplish PLS's mission. I agree to comply with all existing and future Policies and Procedures concerning the security and confidentiality of Confidential Information.

Permitted and required access, use and disclosure:

• I will access, use or disclose Confidential Patient Information (PHI) only for legitimate purposes of diagnosis, treatment, obtaining payment for patient care, or performing other healthcare operations functions permitted by HIPAA, including all applicable state and federal laws and regulations governing the same and I will only access, use or disclose the minimum necessary amount of information needed to carry out my job responsibilities.

• I will protect all Confidential Information to which I have access, or which I otherwise acquire, from loss, misuse, alteration or unauthorized disclosure, modification or access including: 1. making sure that paper records are not left unattended in areas where unauthorized people may view them; 2. using password protection, screensavers, automatic time-outs or other appropriate security measures to ensure that no unauthorized person may access Confidential Information from my workstation or other device; 3. appropriately disposing of Confidential Information in a manner that will prevent a breach of confidentiality and never discarding paper documents or other materials containing Confidential Information in the trash unless they have been shredded; and 4. safeguarding and protecting portable electronic devices containing Confidential Information including laptops, smartphones, PDAs, CDs, and USB thumb drives.

• I will disclose Confidential Information only to individuals who have a need to know to fulfill their job responsibilities and business obligations.

• I will comply with PLS's access and security procedures, and any other policies and procedures that reasonably apply to my use of the computer systems and/or my access to information on or related to the computer systems including off-site (remote) access using portable electronic devices.

Prohibited access, use and disclosure:

• I will not access, use or disclose Confidential Information in electronic, paper or oral forms for personal reasons, or for any purpose not permitted by PLS policy, including information about co-workers, family members, friends, neighbors, celebrities, or myself. I will follow the required procedures of PLS to gain access to my own PHI in medical and other records.

• If my association with PLS ends, I will not subsequently access, use or disclose any Organization Confidential Information and will promptly return any security devices and other Organization property.

Proximity Lab Services

16922 Telge Road, Suite #2
Cypress, TX 77429
Phone: (210) 316-1792
E-mail: robert.castaneda@proximitylabservices.com

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Confidentiality Agreement

- I will not engage in the transmission of information, which is disparaging to others based on race, national origin, sex, sexual orientation, age, disability or religion, or which is otherwise offensive, inappropriate or in violation of the mission, values, policies or procedures of PLS.
- To the extent applicable, I will not utilize PLS network to access Internet sites that contain content that is inconsistent with the mission, values and policies of PLS.

Accountability and Sanctions:

- I will immediately notify PLS if I believe that there has been improper/unauthorized access to PLS's Portal or improper use or disclosure of Confidential Information in electronic, paper or oral forms.
- I understand that PLS will monitor my access to, and my activity within, PLS's Portal, and I have no rightful expectation of privacy regarding such access or activity.
- I understand that if I violate any of the requirements of this Acknowledgement and Agreement, I may be subject to disciplinary action, my access may be suspended or terminated and/or I may be liable for breach of contract and subject to substantial civil damages and/or criminal penalties.
- In the event my login ID, password or other information that enables access to PLS's portal is compromised, I will report such information to PLS's Security Official or Privacy Official immediately.

Network:

- PLS may suspend or discontinue access to protect the Portal or to accommodate necessary down time. In an emergency or unplanned situation, PLS may suspend or terminate access without advance warning.
- PLS may terminate this agreement, user access and use of Confidential Information at any time for any reason or no reason. The following provisions apply to physicians / physician practices; other individual or facility providers; vendors that are not a business associate of PLS or any other unaffiliated organization:
- I accept responsibility for all actions and/or omissions by my employees and/or agents.
- I agree and will ensure that each employee and/or agent of my organization or practice will be required to obtain a separate login, password and I will not authorize or permit, under any circumstance, any person to utilize the logon, password or individual information of another person.
- I agree to notify PLS within 5 business days if any of my employees or agents who have access to PLS's portal no longer need or are eligible for access due to
leaving my practice/company, changing their job duties or for any other reason.
- I agree to report any actual or suspected privacy or security violations made by my employees and/or agents to PLS.
- I understand that PLS may terminate my employee and/or agent's access in their sole and absolute discretion. I also acknowledge that I may be subject to penalties or liabilities under state or federal laws. I understand that if PLS prevails in any action to enforce this Agreement, PLS will be entitled to collect its expenses, including reasonable attorneys' fees and court costs from me.

Responsible Party Signature: _____ Date: _____

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