British Columbia Healthcare Professional (HCP) Registration Form

Is this a(n)	☐ New Provider Registration ☐ Additional Clinic location ☐ Change of address (If yes, please provide previous clinic name and address below) Old Clinic Name and Address: _____

Last Name:	First Name:
HCP Designation: ☐ ND	License Number: License Date:

Note: If registration credentials are not available on-line, we may request a copy for verification.

Clinic Name:		
Clinic Address:		
City:	Province:	Postal Code:
Clinic Phone Number:	Website:	
Fax Number:	Email:	

After Hours Call Number (Required): _____

** For the communication of Critical and Notifiable results to provide consistent patient care and to comply with accreditation requirements, an afterhours call number is required**

Reports by: ☐ Online (RMA - drOPsite™; LifeLabs - Excelleris: Complete User Acknowledgment attached)
☐ Canada Post
☐ Fax

Would you like to be listed on our website? ☐ Yes, by Name & Designation ☐ Yes, by Clinic Name ☐ No

Would you like to subscribe to our monthly email Newsletter? ☐ Yes ☐ No

* **Note**: Based on current accreditation criteria not all laboratory tests are available to all healthcare professionals.

LifeLabs Payment Method (Mark selection with check mark ☑ below)

☐ Invoice ☐ Credit Card (Complete and include Credit Card Authorization Form)

RMA Payment Method and Options (Mark selection with check mark ☑ below)

☐ **Option 1: Healthcare Professional Pays RMA**

Healthcare Professional pays wholesale price for all tests.
- ☐ Invoice
- ☐ Credit Card (Complete and include Credit Card Authorization Form)

☐ **Option 2: Patient Pays RMA**

Note: Patient Pay may not be available for all tests including LifeLabs offerings.

Healthcare Professional is responsible to ensure patients know their credit card will be charged upon receipt of sample for full retail price, plus applicable taxes.

Contact Client Services for Patient Credit Card Authorization Form.

Pages 1 & 2 (page 2 must be signed by requesting Healthcare Professional) are required for registration completion

Billing Information (Only complete if different from information above) **Note this address does not need to match the address used for your credit card. It is strictly used for mailing invoices should you want them going to a location different from your clinic address**		
Name:		
Address:		
City:	Province:	Postal Code:
Phone Number:	Fax Number:	
Email:		

Service Terms	
Pricing	RMA Price List and LifeLabs Naturopathic Price List
Validity	Prices are subject to change with 30 days prior notice
Payment	Net 15 days for RMA testing and Net 30 days for LifeLabs testing Client may pay LifeLabs / RMA by: a. Cheque; b. EFT – contact Accounts Receivable at 1-877-377-1129 ext 45338; or c. Credit Card – a 2% fee will be charged on the full payment. The amount will be waived if payment is made within 10 days of invoice. If Client does not pay the invoiced amount by the due date, at LifeLabs / RMA sole discretion, LifeLabs / RMA may do any or all of the following: a. Charge interest on the outstanding amount at the rate of 2% per month; b. Require Client to pay for future Services in advance; or c. Cease performance of the Services completely.
Change of Service	Reference ranges accompanying the patient report are deemed to be correct and should be used to interpret results. Changes to test methodology, reference ranges, and equipment platform, for the test(s) are not considered a change of service. Either party may change the level of service upon thirty (30) days written notice to either party.

Agreement

I have read the payment options and understand how each option works. I will abide by the terms and conditions of the option I have selected. I understand that this option will apply unless I submit a request to change my preferences. I acknowledge that the information which I provide to RMA will be shared with Genova to open my sub account. I further certify that I am a member of a regulated health profession and I am competent to evaluate test results that are applicable to my scope of professional practice.

Healthcare Professional Signature: _____ Date:_____
(REQUIRED)

Pages 1 & 2 (page 2 must be signed by requesting Healthcare Professional) are required for registration completion

Healthcare Professional (HCP) Credit Card Authorization

Use this form only if paying by Credit Card Please complete this form, scan & email to info@rmalab.com or FAX to toll-free: 866.370.5223 To avoid delays please print all information clearly.	Account Number / Contract Number [FOR INTERNAL USE ONLY]

HCP Last Name:	**HCP First Name:**
Clinic/Pharmacy Name:	
Billing Address:	
City:	
Province:	**Postal Code:**
Phone: ( )	**Fax: ( )**
Email:	
Type of Credit Card: ☐ Visa ☐ MasterCard	**Receive Receipts By:** ☐ Mail ☐ Email (listed above)
Card Number:	
Expiry Date:	**CVD/CVV:**
Name on Credit Card if different from above:	

IMPORTANT NOTES: for Healthcare Professional using CLINIC CREDIT CARDS

- If you are authorizing Rocky Mountain Analytical and LifeLabs to use a CLINIC CREDIT CARD, please list the names of all Health Providers who are authorized to use this card in the boxes below.
- It is your responsibility to notify us of all changes regarding the use of your credit card.

HCP Full Name		**Authorized to use card listed above:**	☐ Yes ☐ No
HCP Full Name		**Authorized to use card listed above:**	☐ Yes ☐ No
HCP Full Name		**Authorized to use card listed above:**	☐ Yes ☐ No
HCP Full Name		**Authorized to use card listed above:**	☐ Yes ☐ No

Service Terms	
Payment	Net 15 days for Rocky Mountain Analytical Net 30 days for LifeLabs

I authorize Rocky Mountain Analytical and LifeLabs to bill my credit card (personal or clinic) for the requested laboratory services. If for any reason my credit card is not accepted I understand that I am financially responsible to Rocky Mountain Analytical and LifeLabs and that Rocky Mountain Analytical and LifeLabs may bill me based on the full price for the laboratory work performed.

Date:	**Signature of Card/Clinic Owner:**

200 – 3500 Gilmore Way
Burnaby, BC Canada V5G 4W7
1-866-728-4777

Excelleris Electronic Distribution Application
Health Care Provider Acceptable Use Acknowledgement

Excelleris provides a communications infrastructure allowing authorized physicians and health care providers to access personal health information that is stored and exchanged through the Excelleris system.

By signing below, the physician and health care provider agrees to abide by the following standards of acceptable use:

1. I agree to take full responsibility for the actions of my staff that I authorize to be provided access to the Excelleris Launchpad application. Further, I will inform Excelleris of all staff changes that require adjustments to Excelleris Launchpad accounts.

2. I hereby agree that the personal health information I access, or that I authorize my staff to access, through the Excelleris Launchpad application will be held in the strictest of confidence and in accordance with applicable privacy legislation.

3. I hereby agree that all personal health information that is accessed through Excelleris Launchpad, whether by me or by my staff, will be used for the sole purpose of providing patient care.

HEALTH CARE PROVIDER INFORMATION		
FIRST & LAST NAME	**SIGNATURE**	**MSP#** (if applicable)
CLINIC NAME AND ADDRESS OF PRACTICE		**DATE** (YYYY/MM/DD)
TELEPHONE NUMBER	**EMAIL ADDRESS**	**FAX NUMBER**

Please select the report delivery method (select one)

☐ **LAUNCHPAD**		
Authorized staff to be provisioned with Excelleris Launchpad account for the above location.		
FIRST & LAST NAME	**FIRST & LAST NAME**	**FIRST & LAST NAME**

☐ **ELECTRONIC MEDICAL RECORDS (EMR)**	
Indicate the EMR vendor name for our reference and contact your EMR support to initiate the set up. Please provide a fax number for delivery of report types not supported by your EMR.	
EMR NAME	**FAX NUMBER**

☐ **FAX**
Select this option if fax is your preferred primary method of delivery.
FAX NUMBER

NOTE: For fax delivery, please return this form via fax to 604-291-6837 in order to validate the fax number for the delivery of reports.

Once complete, please return via email to clientservices@excelleris.com or fax to 604-291-6837

SCHEDULE A