SYNAPS Dx
BIOMARKER TECHNOLOGY

NEW ○ CHANGE ○

NEW ACCOUNT FORM

PRACTICE INFORMATION

Today's Date: _____ Practice specialty: _____

Name of Practice: _____ Phone: _____

Address: _____ Fax: _____

_____ Office Days: _____

City/State/Zip code: _____ Office Hours: _____

For delivery purposes, please note any specific instruction, i.e. closures, half days, etc in the notes box

PROVIDER INFORMATION

Provider Name: _____

NPI#: _____ Email: _____

OFFICE CONTACT

Medical Delegate Contact: _____

Email: _____

Phone: _____

Kit Order Contact: _____ Billing Contact: _____

Email: _____ Email: _____

Phone: _____ Phone: _____

DISCERN™ REFERRAL NETWORK

☐ By clicking this box, I would like to participate in the DISCERN™ Referral Network. Patients interested in the DISCERN™ test will be provided contact information for practices included in this Network.

Notes:

SYNAPS Dx

Synaps Dx Sales Representative: _____

A new account form is required for each provider in the practice prescribing the DISCERN™ test

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NEW ACCOUNT ACKNOWLEDGMENT & SIGNATURE FORM

- I understand that I can contact the NeuroDiagnostics, Inc., dba Synaps Dx (SDx) laboratory, should I have questions regarding the appropriateness of any test order.
- I hereby acknowledge that SDx will perform the DISCERN™ test, which includes the Morphometric Imaging and PKCε assays, and may also include the AD Index assay as deemed necessary by SDx testing protocols.
- SDx will perform an insurance verification and inform me or my staff of any out-of-pocket costs that the patient may be required to pay. If a copayment or remaining annual deductible is required by the patient's insurance or no reimbursement is identified, I or my staff will communicate with the patient to gain their consent to perform the biopsy, and that they will pay SDx any identified out-of-pocket costs. Should they not agree to the out-of-pocket costs, the test will not be ordered.
- I understand that SDx will handle insurance claims for the tests I order using the current CPT code(s).
- I understand that by ordering this test, I deem it medically necessary based on my diagnosis of the patient, and I authorize the use of the patient's medical information to support SDx billing for the tests performed. Additionally, I agree to provide appropriate and accurate diagnosis codes to enable the lab to perform and bill effectively on my patient's behalf.
- Since SDx will perform the billing for the test, should Medicare, Medicaid, or other insurance providers request documentation, I will provide signed written orders from the patient's medical records to the requesting party within a reasonable time.

Practice Name: _____
(print)

In the event of multiple providers within a group practice, each provider must sign a separate form to indicate their acknowledgment.

Provider's Name: _____ Date: _____
(print)

Provider's Signature: _____ Date: _____

**Reference Laboratory: NeuroDiagnostics, Inc. dba Synaps Dx, Rockville, MD CLIA #21D2130277*

FAX FORM TO (301) 576-8629 OR EMAIL TO PROVIDERS@DISCERNTEST.COM