

## HAGYARD LABORATORY CLIENT INFORMATION FORM

### CLIENT INFORMATION

DOCTOR NAME: \_\_\_\_\_ DR. ACCR. CODE: \_\_\_\_\_

CLINIC NAME: \_\_\_\_\_ EMAIL: \_\_\_\_\_

PHONE: \_\_\_\_\_ MOBILE: \_\_\_\_\_

LIST ADDITIONAL DOCTORS FROM YOUR CLINIC WHO MAY SUBMIT SPECIMENS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### CLIENT ADDRESS

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

BILLING ADDRESS *(if different from above)*

STREET ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE: \_\_\_\_\_ ZIP CODE: \_\_\_\_\_

### BILLING OPTIONS

BILL EACH DOCTOR INDIVIDUALLY AT PRACTICE

BILL CLINIC AS A GROUP FOR ALL DOCTOR SUBMISSIONS

### REPORTING OPTIONS

EMAIL ADDRESS \_\_\_\_\_

\_\_\_\_\_

CRITICAL RESULTS WILL BE COMMUNICATED VIA PHONE OR TEXT MESSAGE.

Please complete and email form to [hdmlab@hagyard.com](mailto:hdmlab@hagyard.com). For questions regarding laboratory service, please contact us at (859) 259-3685.

We appreciate the opportunity to support your diagnostic testing needs with timely, high-quality results.