

## New Account Registration

Allergy/Covid-19 Lab Services

Please fax or email this completed form to:

800-434-7514 or [jgilbert@birddogmd.com](mailto:jgilbert@birddogmd.com)



In order to provide seamless testing, shipping, processing, and reporting the following information is required. All results will be sent to an online HIPAA complaint portal which can be accessed by the Provider and Technician.

### CLINIC INFORMATION

Clinic Name \_\_\_\_\_ Specialty \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Practice Manager \_\_\_\_\_

Weekly Patient Volume \_\_\_\_\_ Insurance Mix: Commercial \_\_\_\_\_ Medicare \_\_\_\_\_

### PROVIDER INFORMATION

Provider Name \_\_\_\_\_ Individual NPI \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Services I want:  Blood finger prick allergy  Covid-19 Antibody  
 Covid-19 Molecular

### TECHNICIAN INFORMATION

This is the person that will ship samples, pull reports, and order supplies from the online portal. They must provide a cell phone and email in order to access the portal.

Name \_\_\_\_\_ Title \_\_\_\_\_

Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

### Provider Acknowledgment

I hereby acknowledge, as an Authorized Signee of the above Clinic, that our patient's lab samples will be sent to Spiriplex to perform blood allergy testing and/or Global7 Diagnostics for Covid-19 testing as directed by the individual patient Test Requisition Form(s).

Authorized Signee (print) \_\_\_\_\_ Position \_\_\_\_\_

Authorized Signature \_\_\_\_\_ Date \_\_\_\_\_