SYNAPS Dx
BIOMARKER TECHNOLOGY

12358 Parklawn Dr.
Rockville, MD 20852
301-294-7026

NEW ◯ CHANGE ◯

NEW ACCOUNT FORM

PRACTICE INFORMATION

Today's date: _____ **Start date:** _____

Name of the practice: _____ Practice specialty: _____

Address: _____ Phone: _____

City/State/Zip code: _____ Fax: _____

OFFICE CONTACT

Kits to be sent to: _____ Billing Contact: _____

Email: _____ Email: _____

Phone: _____ Phone: _____

CLINICIAN INFORMATION

Clinician Name: _____

NPI# _____ Email: _____

Notes:

A new form is required for each clinician who will order the test.

SYNAPS Dx
BIOMARKER TECHNOLOGY

NEW ACCOUNT ACKNOWLEDGMENT & SIGNATURE FORM

- I understand that I can contact the NeuroDiagnostics, Inc. dba Synaps Dx (Synaps Dx) laboratory, should I have questions regarding the appropriateness of any test order.
- I hereby acknowledge that the laboratory will perform the skin biopsy for DISCERN™ test which may include Morphometric Imaging, PKCε and AD Index (ERK1 and ERK2) as directed by the Synaps Dx laboratory.
- I understand by ordering the test through the online portal I deem the test necessary, and I authorize use of patient's medical information.
- I understand that it is my responsibility to determine the medical necessity of tests I have requested for the diagnosis of my patients. I agree to provide diagnosis codes, defined to the highest level of specificity for each test that I order to confirm medical necessity and to enable the lab to bill effectively on my patient's behalf. Tests that are deemed medically unnecessary may result in a denial of payment and/or penalties.
- I understand that the Office of Inspector General (OIG) has cautioned: "Using a customized profile may result in the ordering of tests which are not covered, reasonable, or necessary" and "OIG takes the position that an individual who knowingly causes a false claim to be submitted may be subject to sanctions or remedies available under civil, criminal, and administrative law."
- I understand that the lab will be billing third parties for the tests I ordered using the CPT codes noted in the Annual Notice to Physicians.
- Synaps Dx will perform an insurance discovery and will inform me or my staff of any out-of-pocket costs that the patient may be required to pay. If there is a copayment required or no reimbursement 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 out-of-pocket costs.
- If 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 72 hours.
- **In case of multiple physicians within a group practice, each practitioner must sign a separate form to indicate their acknowledgment.**

Clinician's Signature: _____ Date: _____

Clinician's Name (please print): _____

Clinic Name: (please print): _____

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

FAX FORM TO (301) 576-8629 OR EMAIL TO INFO@SYNAPSDX.COM