



PONYA DIAGNOSTICS
CLARITY THROUGH SCIENCE

CLIENT ONBOARDING FORM

START DATE REQUEST: _____

ACCOUNT INFORMATION

ACCOUNT NAME:	CONTACT NAME:
PHONE:	CONTACT TITLE:
FAX:	CONTACT PHONE:
ADDRESS:	CONTACT EMAIL:
	LUX REP:

PANELS ORDERED & EST. MONTHLY VOLUME

<input type="checkbox"/> Molecular STI Panel	<input type="checkbox"/> Comprehensive PGx Panel	<input type="checkbox"/> Other Testing Requests:
<input type="checkbox"/> Molecular UTI Panel	<input type="checkbox"/> Urine Toxicology	<input type="checkbox"/> _____
<input type="checkbox"/> Molecular UTM Panel	<input type="checkbox"/> Oral Toxicology	<input type="checkbox"/> _____
<input type="checkbox"/> Molecular UA w/ PCR+ABX+AST	<input type="checkbox"/> D/L Isomer	<input type="checkbox"/> _____
<input type="checkbox"/> Molecular Vaginitis Panel	<input type="checkbox"/> LUXGuard™ (DNAA)	<input type="checkbox"/> _____
<input type="checkbox"/> Molecular Wound Panel		<input type="checkbox"/> _____
<input type="checkbox"/> Molecular Fungal Panel		<input type="checkbox"/> _____
<input type="checkbox"/> Respiratory Pathogen Panel		
<input type="checkbox"/> Comprehensive Blood Panels		

BILLING TYPE

☐ Insurance ☐ Client Bill (Approval Required) ☐ Patient

REPORTING PREFERENCE

☐ Fax to Practice ☐ Email to Practice ☐ Email to Provider ☐ EMR Integration REQUEST

SHIPPING INFORMATION

<input type="checkbox"/> Courier Pick-up (Georgia Only)	<input type="checkbox"/> FedEx Shipping	<input type="checkbox"/> Delta Dash (For large volume)
<input type="checkbox"/> Courier Pick Up Time: _____	<input type="checkbox"/> UPS Shipping	
	<input type="checkbox"/> Saturday Deliver	

CRITICAL CONTACT INFORMATION

CONTACT NAME:	EMAIL:
PHONE:	NOTES:



PONYA DIAGNOSTICS
CLARITY THROUGH SCIENCE

PHYSICIAN AUTHORIZATION FORM

PORTAL ACCESS: INDIVIDUALS AUTHORIZED TO ELECTRONICALLY ACCESS PORTAL AND ORDER TESTS

NAME:	EMAIL:
NAME:	EMAIL:
NAME:	EMAIL:
NAME:	EMAIL:
NAME:	EMAIL:

PHYSICIAN SIGNATURE RECORD

PLEASE INCLUDE ALL PROVIDERS WHO ARE AUTHORIZED TO ORDER LAB TESTING. THE INDIVIDUAL LISTED BELOW ARE AUTHORIZED TO SIGN PATIENT TEST REQUISITIONS, LIMITED TO MD, DO, PA OR APRN (CNP). RNS ARE NOT ALLOWED TO ORDER OR SIGN FOR LAB TESTING WITHOUT PHYSICIAN'S AUTHORIZATION (SEE ABOVE.)

LAST NAME	FIRST NAME	NPI#	SIGNATURE	DATE

I UNDERSTAND AND HEREBY ACKNOWLEDGE THAT I WILL ONLY ORDER TESTS THAT I BELIEVE TO BE MEDICALLY NECESSARY TO ENSURE PATIENT COMPLIANCE WITH THE THERAPY THAT I HAVE PRESCRIBED.