



**QUESTIONS? PHONE:**  
 (866)-647-2847  
 (317) 856 2681  
**FAX COMPLETED FORM TO:**  
 (317)-856-3685

CLIENT REGISTRATION		
LABORATORY INFORMATION		
Facility Name:		
Laboratory Name:		
Address:		
City:	State:	Zip:
Lab Phone # for questions: (     )	email :	
Primary Contact Name:	Job Title:	
Direct Phone: (     )	Direct email :	
Main Results Fax: (     )	Alternate Fax: (     )	
<b>To ensure confidentiality, results will only be sent to the FAX number(s) listed above</b> <b>Invoices will be sent to Ordering Providers Only . <u>WE DO NOT BILL INSURANCE</u></b>		
INVOICING INFORMATION		
Contact Name :	Job Title	
Invoicing Address:		
City:	State:	Zip:
Phone: (     )	email :	
Is a PO# required for all orders (please circle)?:                      YES                      NO		
<b>All new client registrations require signature by a representative of the client who in signing agrees and guarantees payment. <u>A signed form must be on file before tests can be resulted.</u></b>		
Signature : _____ Date : _____ Print Name : _____		
FOR MIRAVIDA USE		
Client Account Number:		Customer ID :
Established by : _____ Date : _____		

**MiraVista Diagnostics**  
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