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: ______________________

DISCERN™ REFERRAL NETWORK

☐ By clicking this box, I would like to participate in the DISCERN™ Referral Network. Patients interested in the DISCERN™ test will be provided contact information for practices included in this Network.

Notes:

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

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NEW ACCOUNT ACKNOWLEDGMENT & SIGNATURE FORM

- I understand that I can contact the NeuroDiagnostics, Inc. dba Synaps Dx (SDx) laboratory, should I have questions regarding the appropriateness of any test order.
- I hereby acknowledge that SDx will perform the skin biopsy for DISCERN™ test which will include the Morphometric Imaging and PKCε assays and may include AD Index (ERK1 and ERK2) as deemed necessary by SDx testing protocols.
- SDx 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 a copayment or remaining annual deductible is required by their insurance or no reimbursement is 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 identified out-of-pocket costs. Should they not agree to the out-of-pocket costs, the test will not be ordered.
- I understand that SDx will be billing third parties for the tests I ordered using the CPT codes noted in the Annual Notice to Physicians.
- I understand by ordering the test, I deem it necessary based on my diagnosis of the patient and I authorize use of patient's medical information to support SDx billing for the tests performed. Additionally, I agree to provide diagnosis codes to enable the lab to bill effectively on my patient's behalf.
- Since SDx will perform the billing for the test, should 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 a reasonable time.
- **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