



NEW ACCOUNT FORM (all fields must be completed)

EVENTS

Current Date: _____
Submitting Representative _____

EVENT NAME _____

Will A2Z be supplying swabber? []Yes []No Will QR codes need to be created for EVENT Registration? []Yes []No

Table with 5 columns: Date Of Event, Hours Of Testing, # of PCR, # of Antigen, # of Rapid PCR (Accula)

EVENT LOCATION & CONTACT INFORMATION

Address _____ Suite/Room/Floor _____
City _____ State _____ Zip _____
Main Phone _____ Cell Phone _____
Event Coordinator _____ Email _____

Patient Results

Will EVENT Coordinator Receive all Patient Results? []Yes []No
If YES enter EVENT Coordinator EMAIL _____
Would you like patients to receive results via Text or Email? []Yes []No

Payment

Insurance []Yes []No
Client bill (EVENT to be Billed & Pay for Testing for Uninsured/Foreign Individuals) []Yes []No
Patient Pay (Uninsured/Foreign Individuals to Pay for Testing) * []Yes []No
Event to pay for A2Z swabber (\$) []Yes []No
*This option Requires A2Z approval

Comments

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