

***Required field**

PRACTICE INFORMATION

Practice Name:* _____

Practice Specialty:* _____

Address:* _____

Address 2: _____

City:* _____

State:* _____ Zip:* _____

Phone:* _____

Fax:* _____

FOR PATIENTS SEEN AT THIS PRACTICE:*NOTE: At this time, self-pay is the only supported option.*

- Patients will typically self-pay to Pathway Online
- The practice will typically pay Pathway for the testing and will bill insurance/patient.
- Pathway Genomics will typically bill Patient's Insurance

NUMBER OF KITS:

How many collection kits would you like to keep on-hand at your practice?

 6 12 24 More _____**CONTACT PERSON:** (If different from ordering physician)

First Name:* _____

Last Name:* _____

Email Address:* _____

Phone:* _____

ORDERING PHYSICIAN

(To register multiple physicians, please use additional practice forms attached to a fully completed form, and fill out just the information below.)

First Name:* _____

Last Name:* _____

Email Address:* _____

Phone:* _____

NPI#:* _____

Specialty:* _____

States Licensed In:* _____

- Deliver Reports to Web Account Mail Reports to Practice

NOTE: At this time, Pathway is only supporting mail delivery to physicians.

- Sign Up for MD Newsletter