Client Information Form

Peachstate Health Management, LLC A Division of AEON Global Health Corp. 2225 Centennial Drive, Gainesville, Georgia 30504
Phone: (678) 276-8412 Fax: (470) 290-5071
Email: clientservices@aeonglobalhealth.com

ACCOUNT INFORMATION

Account Name: ______________________ Phone: ______________ Fax: ______________

Address: ______________________ City: ______________ State: ______ Zip: ______________

PRIMARY CONTACT INFORMATION

Contact Name: ______________________ Contact Title: ______________________

Phone: ______________ Fax: ______________ Email: ______________________

BILLING METHOD & ESTIMATED VOLUME

☐ Insurance ☐ Patient ☐ Client (approval required) ☐ Workers Comp

Estimated Monthly Volume: _____ Tox _____ PGx _____ Blood _____ ColoHealth (Coming soon)

REPORTING PREFERENCE

Preferred Method: ☐ Fax ☐ Web Portal (http://www.aeon.labscv.net) ☐ EMR Name: ______________

Web Portal

Desired Username: ______________________ Desired Password: ______________________

Username must be at least 6 alphanumeric characters (not case sensitive); password must be 8 to 10 characters (not case sensitive) and contain a number and special character

SHIPPING PREFERENCES

Daily Pick-up Needed: ☐ Yes ☐ No Desired Pick-up Time: _____:_____

Pick-up Location: ☐ Same Address Listed Above

Address: ______________________ City: ______________ State: ______ Zip: ______________

SALES GROUP/SALES REP INFORMATION

Sales Group: ______________________

Sales Rep: ______________________ Rep Email: ______________________

Rep Phone: ______________

Sales Rep: ______________________ Rep Email: ______________________

Rep Phone: ______________

Know better. Live better.

Physician Authorization Form

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CLIA ID: 11D2031378

ACCOUNT INFORMATION

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Address: ______________________________ City: ________________ State: ________ Zip: ____________

ELECTRONIC ORDER ENTRY AUTHORIZATION

I hereby authorize the individuals listed below to electronically access AEON's web portal and order tests at my direction.

Full Name: ______________________________ Email: ______________________________

Full Name: ______________________________ Email: ______________________________

Full Name: ______________________________ Email: ______________________________

Full Name: ______________________________ Email: ______________________________

Full Name: ______________________________ Email: ______________________________

Full Name: ______________________________ Email: ______________________________

Please include ALL providers who are authorized to order lab testing. The individuals 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.

Last Name, First Name	NPI#	MD/DO Phys. Asst.	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.