EMPLOYER DRUG
TESTING SOLUTIONS

New Account Setup Form

Name of Company: _____
Main Contact Name(s):_____
Alt. Contact Name(s):_____
Address: _____City: _____State: ____ Zip: _____
Phone: (____)_____ Fax: (____)_____
E-Mail: _____

[__] If the billing address is the same as above, please mark it with “X”. If the billing address is different than above, please include below.

Name of TPA:_____
Billing Contact Name(s): _____
Address: _____City: _____ State: ____ Zip: _____
Phone: (____)_____ Fax: (____)_____
E-Mail: _____

Please note that EDTS will sends results, billing and confidential information to the above fax/e-mail. We require that you keep these secure due to sensitive information that may be transmitted.

I, (print name) _____ authorize EDTS of the Ozarks to charge the credit card listed below, for all charges including drug/alcohol screenings, physical exams, and incidental charges as requested/deemed necessary for my account. Please note that EDTS will ALWAYS call before running a card for payment of a service/invoice.

Type of Card: [__] VISA [__] MasterCard [__] Discover [__] AMEX
Card #:_____ Exp. Date: ____/____/_____ 3-4 digit security #: _____

If you do not plan on paying for services with a card, EDTS can also accept cash/check at the time of service or 15 days from date of invoice via mail. EDTS reserves the right to terminate this agreement or discontinue servicing above named company, without notice, if the company is unable to make timely payments on account past 30 days. EDTS additionally reserves the right to change all applicable fee(s)/structure of agreement with 30 days written notice to the company.

Signature of Company Representative:_____

Signature of EDTS Representative: _____

Effective Date: ____/____/_____