



Rocky Mountain Analytical

PROVIDER REGISTRATION

Please complete this form and FAX to 866.370.5223 or 403.241.4516

To avoid delays please print all information clearly.

Provider Last Name:	Provider First Name:		
Provider License Number:	Designation: please specify, ND, MD, etc.		
Clinic / Pharmacy Name:			
Clinic / Pharmacy Address:			
City:	Province:	Postal Code:	
Phone: ()	FAX: ()	Email:	
Send Test Reports by: (check one or two options)	Email <input type="checkbox"/>	FAX <input type="checkbox"/>	Regular Post <input type="checkbox"/>
Do you want to be listed on our website as a Provider of our testing services: Yes <input type="checkbox"/> No <input type="checkbox"/>		If yes, please specify how (pick only one). Your Name: <input type="checkbox"/> or Clinic / Pharmacy Name: <input type="checkbox"/>	

Option 1: Provider Pays RMA. Includes volume discounts (Saliva).

Please select billing method: Credit Card* or Invoice

* Please complete and FAX a Credit Card Authorization.

- Provider pays wholesale price for all tests.
- If invoiced, Provider is billed bi-weekly for the laboratory work performed by RMA. Payment terms are net 15 days.
- If accounts are not kept current RMA will make appropriate collection efforts to bring the account up to date.
- RMA reserves the right to assign credit limits to accounts.
- If credit card is your method of payment, the card is charged once testing is complete and report sent.

Option 2: Patient Pays RMA. No volume discounts with Option 2.

- Provider is responsible to ensure patients know they must submit full payment with their sample. Credit Card or Cheque.
- If patient chooses to pay with Credit Card a Credit Card Authorization must be completed.
- Patient must enclose full retail price plus GST with sample. (No HST)

Note: Patient Pay is **not available** for Conventional Labs.

Confirm the Billing Method you choose: Option 1 Option 2

I have read the payment options and understand how each option works. I will abide by the terms and conditions of the option I have selected. I understand this option will apply unless I submit a request to change my preferences. I further certify that I am a member of a regulated health profession.

Provider Signature:

RMA TEST PANELS (please check all you are interested in)

<input type="checkbox"/>	Saliva Hormones (sex hormones)
<input type="checkbox"/>	Complete Estradiol - Progesterone Profile (CEPP)
<input type="checkbox"/>	Estrogen Metabolism Ratio
<input type="checkbox"/>	Omega 3 Fatty Acids
<input type="checkbox"/>	Urinary Thyroid Assessment
<input type="checkbox"/>	Hair Element Analysis
<input type="checkbox"/>	Diatest™ Breath Test (Insulin Resistance)
<input type="checkbox"/>	Allergy

Conventional Labs

<input type="checkbox"/>	Calgary Lab Services
<input type="checkbox"/>	LifeLabs British Columbia
<input type="checkbox"/>	LifeLabs Ontairo
<input type="checkbox"/>	Valley Medical Labs (Okanagan, BC)

Other, please specify:

SpectraCell Test Panels:

If you are interested in the following SpectraCell tests please check the boxes below.

RMA supports these tests by providing information on behalf of SpectraCell but SpectraCell tests must be ordered directly through SpectraCell in the US. RMA Client Services are happy to explain the process to you.

<input type="checkbox"/>	MicroNutrient	<input type="checkbox"/>	Telomere
<input type="checkbox"/>	LPP	<input type="checkbox"/>	LPP+

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