Precision Pathology Laboratory Services

PRECISION PATHOLOGY LABORATORY
"A Spirit of Excellence"

NEW CLIENT INFORMATION

CLIENT ID: _____

LEGAL NAME	
DBA NAME	
ADDRESS	
PHONE	
FAX	
WEBSITE	
CLINIC NPI	
Agreement Contact Name and Email	
TYPES OF SPECIMENS	
QUIRKS/ COMMENTS	

START DATE			
OFFICE CONTACT			
OFFICE EMAIL			
ANTICIPATED VOLUME			
FORMALIN VIALS	THIN PREP	STI TESTING	PER DAY/ WK/ MOS
FAX		LIGOLAB CONNECT	
☐ Y ☐ N		☐ Y ☐ N	

PHYSICIAN INFORMATION

Name	Email	Mobile Phone	NPI

NOTES

Report Distribution Agreements

At **minimum** please choose 1 report distribution (you may choose all 3): Email, Fax , or LigoLab Connect
We recommend choosing LigoLab Connect (online report viewing and report storing) and Email

Email Verification Agreement

The undersigned Client hereby authorizes Precision Pathology Laboratory Services (PPLS) and/or its affiliated laboratories to send Protected Healthcare Information as that term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160-64) to the following email address(es) to the extent such transmission is deemed by Institute for PPLS to be reasonably necessary as part of the professional business relationship between PPLS and Client.

EMAIL ADDRESS *(PLEASE PROVIDE ALL EMAILS THAT PPLS MAY TRANSMIT TO)*

Facsimilie Verification Agreement

The undersigned Client hereby authorizes Precision Pathology Laboratory Services (PPLS) and/or its affiliated laboratories to send Protected Healthcare Information as that term is defined by HIPAA (Health Insurance Portability and Accountability Act of 1996, 45 C.F.R. Parts 160-64) to the following facsimile phone number(s) to the extent such transmission is deemed by Institute for PPLS to be reasonably necessary as part of the professional business relationship between PPLS and Client.

FACSIMILE NUMBER(S) *PLEASE PROVIDE ALL FACSIMILIE NUMBERS THAT PPS MAY TRANSMIT TO*

Client acknowledges to PPLS that Client is solely responsible for adopting and implementing appropriate policies and procedures, including physical safeguards, so that the location, access, and use of such facsimile machine(s) complies with all applicable HIPAA regulations. Client may revoke this authorization or change the facsimile number only by giving PPLS at least five (5) days prior written notice. This revocation may be by facsimile transmission; however a written copy of the revocation must be mailed or delivered by hand to the laboratory as well.

LigoLab Connect Service Privacy Agreement

(PLEASE CHECK BOX IF YOU WOULD LIKE ACCESS TO REPORTS ONLINE) ☐

YOUR ORGANIZATION AGREES TO:

- **Initiate a grant-access request only for individuals who have an express need to view online reports.**
- **Immediately initiate a revoke-access request for individuals who no longer have an express need for access to online reports.**
- **Electronically assign reports only to the individual(s) who has an express need to view them, in accordance with HIPAA's "minimum necessary" use standard.**
- **Implement policies that address the following security practices, at minimum:**
  - **Keep all login information private.**
  - **Never leave a computer/mobile device unattended while logged in to the service.**
  - **Log out as soon as you have finished reviewing results.**
  - **Use the service in a location where onlookers cannot view the computer/mobile device screen.**
- **Take responsibility for any breaches of privacy that occur via any user IDs and passwords that have been granted at your organization's request, regardless of whether or not they are related to HIPAA compliance.**
- **Hold PPLS harmless for any breaches of privacy which occur as a result of inappropriate use of protected health information via any user IDs and passwords that have been granted at your organization's request, regardless of whether or not they are related to HIPAA compliance.**
- **Utilize this service in compliance with all applicable HIPAA regulations**

ACKNOWLEDGEMENT OF RESPONSIBILITY	
Practice Name:	
Representative Signature:	
Representative Printed Name:	
Date of Sign:	

PLEASE SIGN AND RETURN TO:

210-646-9191 (FAX) or flowservicescoodinator@precisionpath.us

REV. 8/26/2025

LigoLab Connect Sign-Up / Change Request

PLEASE COMPLETE ONLY ONE FORM, PER USER, PER FACILITY.
For HIPAA security purposes, no more than two users per Provider, per Location are recommended.
All User Names will remain inactive until the *LigoLab Connect Service Privacy Agreement* has been signed and returned to Precision Pathology Laboratory Services.
All authorizations for web reporting access will be granted and prohibited upon request only.
Authorization changes may take up to forty-eight hours.

ALL FIELDS ARE MANDATORY

PHYSICIAN NAME(S):

PHYSICIAN WORKING LOCATION NAME(S):

USER'S NAME (FIRST AND LAST): PLEASE PRINT
USER'S TITLE: PLEASE PRINT
USER'S EMAIL ADDRESS: PLEASE PRINT
HAS THIS USER EVER BEEN SIGNED UP FOR ORV AT ANY PPLS-SERVICED FACILITY?
If yes, please state the Facility:

PPLS Office Use Only
Date User Activation and Initial: _____

Date User Deactivated and Initial: _____

Database Updated: _____