SCREEN INC.™

CANS-MCI

Computer-**A**dministered **N**europsychological **S**creen

For **M**ild **C**ognitive **I**mpairments

3511 46th Ave N.
Seattle, WA 98105
866-668-9038
www.screen-inc.com

FAX Enrollment Form to 206-260-8884

Practice Demographics				
Physician/Partner Name:	First:	Last:	Title:	Specialty:
Practice/Office Name:				
Name to appear on reports:				
Physical Address: (For Screen Inc. to mail invoice)				Suite:
City:		State:	ZIP:	
Office Phone:	Office Fax:			
Accounts Payable: Responsible for monthly invoice payment to Screen Inc. Invoices sent by FAX or Email				
Contact Person:	Title:			
Direct Phone:	Fax:			
Email:	Check Email ☐ or Fax ☐ for delivery of invoices			
Payment Method: ☐Check ☐Credit Card: (**Screen Inc. will bill $____ per test result)** Payment Terms: **Net 15 days, invoiced monthly**				
☐ Visa ☐ MasterCard ☐ Discover ☐ AMEX	Card Number		Expiration _ _ / _ _	CVV #
Medical Billing: ☐ In-House ☐ Out-sourced				
Contact Person:	Phone:			
Company:	Email:			
Report Details: CANS-MCI is sent as a one or two-page PDF file				
Report Format: ☐ One Page ☐ Two Page				
Email where Reports to be sent:	Backup Email:			
Omit driving statements on the Physician Report ☐				
Reporting Contact (MD, MA, RN, PA, MSW, PhD, DO, NP):	Phone:			
Software, Hardware & Installation Details:				
Operating System must be Windows 7 or newer: _____	☐ 32 Bit ☐ 64 Bit, PC Model:_____			
Installation Fee: $350.00 (per system/office) will show on your first monthly invoice from Screen Inc. Includes: lifetime installation, configuration, staff training, tech support, billing support & upgrades at no additional cost				**$350.00 X** #___Systems
Account Notes:			**Total:**	
Authorization:				
Physician/Authorized Signature:	Date:			
Screen Inc. Account Manager:	Rep Organization:			
***Billing Practice Acknowledgment**: I've received/read and understand the billing practices for the CANS-MCI and agree that the medical practice is responsible for obtaining any prior authorizations or reimbursements from insurance carriers. ☐	Authorized Signature:			