T.O.V.A. ACCOUNT TRANSFER FORM

SENDING OPTIONS: Mail: The TOVA Company
3321 Cerritos Ave
Los Alamitos, CA 90720

Fax: (800) 452-6919 **or** (562) 594-7770 **Email:** info@tovatest.com

For assistance, call: (800) 729-2886 or (562) 594-7700

SECTION 1: TRANSFERER – CURRENT OWNER

I, _____, AM RELEASING RESPONSIBILITY OF T.O.V.A. KIT(S), SERIAL # (S) _____ TO THE FOLLOWING QUALIFIED ENTITY, _____.

I AM THE AUTHORIZED PURCHASER/AGENT. PLEASE MAKE THIS TRANSFER EFFECTIVE THIS DATE: _____. I KNOW THE ACCOUNT(S) MUST HAVE A ZERO BALANCE IN ORDER TO TRANSFER. ANY ORDERS PLACED ON OR BEFORE THIS DATE WILL BE PAID COMPLETELY BEFORE TRANSFER CAN OCCUR.

AUTHORIZED SIGNATURE PRINT NAME AND TITLE

Phone: _____ Email: _____

SECTION 2: TRANSFEREE – NEW OWNER

I, _____, ACCEPT ALL RESPONSIBILITY FOR THE T.O.V.A. KIT(S), SERIAL#(S): _____. I AM THE AUTHORIZED PURCHASER/AGENT FOR ENTITY _____. THE T.O.V.A. (S) WILL BE USED BY QUALIFIED DEGREE/LICENSING PERSONS WITHIN SCOPE.

I OR ENTITY WILL BE RESPONSBLE FOR ANY OBLIGATIONS FROM THIS DATE FORWARD: _____.

AUTHORIZED SIGNATURE PRINT NAME AND TITLE

Phone: _____ Email: _____

TRANSFEREE (NEW OWNER) INFORMATION (PLEA*SE TYPE or write clearly)*

NEW T.O.V.A. PROGRAM OWNER NAME: _____

NEW PRIMARY CLINICAL CONTACT NAME (IF DIFFERENT FROM ABOVE): _____ DEGREE/LICENSE: _____

NEW SECONDARY CONTACT(S): _____ DEGREE/LICENSE: _____; _____ DEGREE/LICENSE: _____;

NEW SHIPPING/MAILING ADDRESS: _____ NEW BILLING ADDRESS: _____

_____ _____

_____ _____

_____ _____

_____ _____

NEW CLINICAL PHONE: _____ NEW BILLING CONTACT: _____

NEW CLINICAL FAX: _____ NEW BILLING PHONE: _____

NEW CLINICAL E-MAIL(S)_____ NEW BILLING EMAIL: _____

AUTHORIZED SIGNATURE PRINT NAME AND TITLE

NEW FACILITY/PRACTICE INFORMATION

Do you want to be on our email list (we will not release or sell your information)? Yes _____ No_____

How did you hear about T.O.V.A.? _____

What type or setting or kind of practice do you have? _____

What populations do you see? _____

How do you plan to use the T.O.V.A. (adhd evaluation____, treatment monitoring____, TBI____, Differentiating Dx_____, Autism_____, Research, ____, Cognitive Baseline_____ EMR_____ Other:_____)

Do you assess___, treat____, both____, or ____refer out for: _____.

Who will be administering the T.O.V.A. test? _____

Do you want to be on our Referral Network?* ☐ Yes (Please complete the following information.) ☐ No

What are your surrounding Areas or Zip Codes: _____

Who is the contact (if different from above): _____

Address (if different from above): _____

_____

_____

_____

Phone # (if different from above): _____ Office Hours: _____

Specialty/Services: _____

Do you accept insurance? If so which: _____