



HEALTH FAIR LABS PAYMENT FORM AND CONSENT

Date: _____

Last Name: _____ First Name: _____ MI: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Date of Birth*: _____ Gender: Male Female

*Patient must be 18 years of age or legally emancipated to request tests.

- Tests marked with (*) requires 12-14 hours fasting. Are you fasting today? Yes No

I request the following laboratory tests and authorize Heritage Health Center Health Fair to complete these tests:

| Mark | Test Name/ ICD 10 Diagnosis Code: Z00.00 | CPT CODES | COST |
|--------------------------|---|---------------------|-------------|
| <input type="checkbox"/> | Blood Typing | 86900, 86901 | \$30 |
| <input type="checkbox"/> | CBC (Complete Blood Count) | 85025 | \$12 |
| <input type="checkbox"/> | CMP (Chemistry Count) | 80053 | \$12 |
| <input type="checkbox"/> | *Health Panel (CMP + Lipids + TSH) | 80053, 80061, 84443 | \$24 |
| <input type="checkbox"/> | Hemoglobin A1C | 83036 | \$15 |
| <input type="checkbox"/> | Color Cancer Screen | G0328 | \$20 |
| <input type="checkbox"/> | *Lipid Panel (Cholesterol) | 80061 | \$12 |
| <input type="checkbox"/> | PSA (Prostate) | 84153 | \$20 |
| <input type="checkbox"/> | TSH (Basic Thyroid) | 84443 | \$12 |
| <input type="checkbox"/> | T4 Free (Thyroid) | 84479 | \$20 |
| <input type="checkbox"/> | Vitamin B12 + Folate | 82607, 82746 | \$30 |
| <input type="checkbox"/> | Vitamin D | 82306 | \$30 |
| <input type="checkbox"/> | Iron Panel (Iron, Transferrin Sat., TIBC) | 82728, 84466, 83540 | \$20 |

** Please read and sign the authorization on second page.



By requesting the laboratory tests, I understand that:

- Laboratory results from Heritage Health Center Health Fair are for informational purposes only and are not a substitute for medical advice, diagnosis or treatment.
- I should consult a health care provider before I stop, start or change any treatment plan, including the use of medication. Heritage Health Center is not responsible for initiating a visit with a health care provider.
- Heritage Health Center employees cannot, by law, interpret lab test results for me beyond the mailed response or any follow-up call. I understand that results within the normal range do not indicate absence of disease.
- I understand that results that fall out of the normal range do not indicate presence of a disease.
- I understand that lab tests are not a substitute for a full medical evaluation by a health care provider.
- I understand that my results will not be sent to a physician and that I am responsible to take my results to my personal medical provider.

Please initial each statement:

_____ I understand Heritage Health Center will mail my lab test results to the address listed. Heritage Health Center is not responsible for a breach of privacy if someone else at the address given accesses these results. Heritage Health Center will attempt to reach me directly, at the telephone number given above, if the abnormal result falls within criteria established by Heritage Health Center policy. If I am not reasonably available at that number, I release Heritage Health Center from liability related to the inability to contact me by telephone.

_____ I understand that Heritage Health Center lab results can ONLY be mailed to the address given and that it is my responsibility to share these results with my provider.

_____ I shall pay Heritage Health Center in full at the time of service. No other billing will occur to any third party. No refund is available. If I am eligible to receive Medicare benefits, I am aware that Medicare does not cover this service and I am fully responsible for payment at this time.

_____ Notice of Privacy Practice (NOPP): My initials acknowledge receipt of the Heritage Health Center Fair NOPP.

[Type here]

[Type here]

1/16/2019 JM



_____ I understand that these test results will not be included in my medical record (if any) kept at Heritage Health Center, nor will they be available to any health care provider unless I release a copy to them.

Signature: _____

Date: _____ **Witness:** _____