

Lab Health Screening Consent Form

Step 1-Fill out your information below:

Name	
Address	
City, State Zip	
Social Security #	
Date of Birth	
Sex	MALE <input type="checkbox"/> FEMALE <input type="checkbox"/>
Phone Number	
*Family Provider	

Step 2-Select the test(s) you'd like to have done:

√	TEST NAME	COST	FASTING REQUIRED
<input type="checkbox"/>	Lipid Panel (Cholesterol, Triglyceride,HDL,LDL,VLDL)	\$20.00	YES
<input type="checkbox"/>	CBC	\$20.00	NO
<input type="checkbox"/>	Glucose	\$10.00	PREFERRED
<input type="checkbox"/>	Blood Type	\$15.00	NO
<input type="checkbox"/>	PSA (Prostate)	\$25.00	NO

Step 3-Pay for your tests at the Business office registration front desk.

(Amount Paid_____ Taken by: _____)

Step 4-Fill out the envelope for your results to be mailed to you in.

Step 5-Read the statement below. Initial the boxes for each section and sign.

CONSENT FOR TREATMENT AND PAYMENT:

- This is to certify that I consent to and authorize the performance of specimen collection and analysis of the above marked laboratory tests. I understand that Buchanan County Health Center is not acting as my doctor and that I have sole responsibility to take appropriate action on the test results and consult my doctor regarding all abnormal test results.
- I agree to take full financial responsibility for the cost of the tests that I request and that payment must be rendered prior to specimen collection. I understand that these tests will not be billed to a third party by Buchanan County Health Center and no results will be sent to any physician or health care provider, unless the results are "critical". If a result is deemed "critical", the laboratory will make every attempt to contact your family provider. If no family provider is listed, the laboratory will contact the patient directly with any critical results.

Signature: _____

Date: _____

*for business office: Enter "N/A" in Meditech (no provider/self-pay)