BCHC Buchanan County Health Center

Lab Health Screening Consent Form

Step 1-Fill out your information below:

Name (Print): _____ DOB: _____

Address: _____

Phone Number: _____ Family Provider: _____

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

√	TEST NAME	COST	FASTING REQUIRED
	CMP (Na, K, Cl, CO2, Glucose, Creatinine, CA, BUN, ALP, AST, ALT, T.Bili, T.Protein, Alb)	$10	Yes
	Lipid (Chol, Trigly, HDL, LDL, VLDL)	$10	Yes
	CBC	$10	No
	Blood Type	$20	No
	Glucose	$10	Preferred
	Hemoglobin A1C	$15	No
	Thyroid Stimulating Hormone (TSH)	$15	No
	Vitamin D	$25	Preferred
	PSA (Prostate)	$15	No
	Iron	$10	No
	Uric Acid	$10	No

Step 3-Pay for your test at the time of registration.
(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: _____