BCHC Buchanan County Health Center

Lab Phone: (319) 332-0875

Lab Walk In Wellness Consent Form

Step 1-Fill out your information below:

Legal 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	ORDER CODES B1WIW-
	CMP (Glucose, Calcium, Sodium, Potassium, Carbon Dioxide, Chloride, Albumin, Total Protein, ALP, AST, ALT, Bilirubin, BUN, Creatinine)	$10	Preferred	COMPNL
	Lipid (Cholesterol, Triglycerides, HDL, LDL, VLDL)	$10	Preferred	LIPIDP
	CBC (WBC, RBC, HGB, HCRT, PLT)	$10	No	CBCND
	Blood Type	$20	No	ABORH
	Glucose	$10	Preferred	GLU
	Hemoglobin A1C	$15	No	GLYA1C
	TSH (Thyroid Stimulating Hormone)	$15	No	TSH3G
	Vitamin D	$25	Preferred	25VITD
	PSA (Prostate-Specific Antigen)	$15	No	PSASCR
	Iron	$10	No	FE
	Uric Acid	$10	No	URIC

Step 3-Pay for your test at the time of registration.
(Amount Paid_______ Cash/Check/Credit Taken by: ________________________)
Step 4-Fill out the envelope for your results to be mailed to you in. Please allow 5 days for results.
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 have requested 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: _____________

B1WIW-: ______________________________

Results Mailed to Patient: __________________

HAR: __________________________________

Dec 2025