

**Laboratory Wellness Screening for Patient-Initiated *(Direct Access)* Testing**

Dear Patient: Please be aware that State regulatory requirements regarding patient-initiated testing do not allow us to send your lab results to your family healthcare provider. Due to the regulatory requirements, only the provider signing below will receive lab results. The provider signing this form may contact you regarding critical values outside of the standard range.

The laboratory tests that you are having performed today fall under a special category and are subject to the following conditions:

* **Payment *(cash / personal check / credit card)* is required at the time of service.**
* **Insurance companies, Medicare, and Medicaid do not accept billing for patient-initiated testing; therefore, Minidoka Memorial Hospital does not bill – or provide billing information – for patient-initiated testing.**
* **A copy of your lab results will be mailed to the address you provide below.**
  1. **(Patient Initials)** A *Notice of Privacy* practices has been made available to me.
  2. As the patient, you are responsible to consult a physician for interpretation and care if results are abnormal.
  3. As the patient, you are responsible to consult a physician for further care if the test results are normal and symptoms continue.
  4. As the patient, you are responsible to follow-up with a medical provider for diagnosis and treatment.

I have read and understand the above statements and consent to have my blood drawn. I have had the opportunity to ask questions and understand the answers provided to my questions.

Signature: Date: Last Name: First Name: Middle Initial: Mailing Address: City: State: Zip: Phone: Date of Birth: Gender:

Family Healthcare Provider:

Provider Signature:                                                                                                                   Date:

ONLY THE FOLLOWING LABS ARE ALLOWED FOR PATIENT-INITIATED TESTING

\*\* 12-14 hour fast required for these tests. You may drink - water only - for \*\* tests.

|  |  |  |
| --- | --- | --- |
| **Mark Test(s) to be Performed** | **Name of Lab Test** | **Cost** |
|  | Complete Blood Count *(CBC with auto differential)* | $ 15.00 |
|  | **\*\***Comprehensive Metabolic Panel *(blood sugar, liver, kidney, electrolytes)* | $ 25.00 |
|  | ESR- *(sedimentation rate)* | $ 10.00 |
|  | Ferritin | $ 15.00 |
|  | **\*\***General Health Panel *(comprehensive metabolic panel, Lipid, CBC and TSH)* | $ 60.00 |
|  | Glycohemoglobin (A1c) | $ 25.00 |
|  | Hemosure-Fecal occult blood test *(sample collection kit)* | $ 10.00 |
|  | Iron/ IBC | $ 35.00 |
|  | **\*\***Lipid *(cholesterol HDL, LDL, VLDL, calculated risk and triglycerides)* | $ 20.00 |
|  | Pregnancy Test, Qualitative *(urine or serum)* | $ 15.50 |
|  | Prostate Specific Antigen *(PSA)* | $ 15.00 |
|  | Protime / INR | $ 25.00 |
|  | Thyroid Stimulating Hormone *(TSH)* | $ 20.00 |
|  | Thyroid- Free T4 | $ 20.00 |
|  | Uric Acid | $ 10.00 |
|  | Urinalysis *(dipstick only)* | $ 25.00 |
|  | Vitamin D-25, Hydroxy | $ 50.00 |
|  | Venipuncture | $ 7.00 |

METHOD OF PAYMENT (circle one): CASH PERSONAL CHECK CREDIT CARD TOTAL DUE $

**Processing Laboratory Personnel**

Initial here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT LABEL**