DIRECT ACCESS TESTING (LAB) ORDER FORM

Personal Information (Please Print):

Name (First, Last, MI)____ Date of Birth___________ Sex (M/F)__________

Address____________________________City__________________________State___________ Zip________________

Phone Number____________________________ TV Number (TVHS Use Only)__________________________________

SELECT YOUR TEST(S) FROM THE LIST BELOW:

✓	Laboratory Test	$$
	CMP (Comprehensive Metabolic Panel)	**$25**
	CBC (Complete Blood Count)	**$25**
	Lipid Profile	**$25**
	Hemoglobin A1c	**$25**
	FT4	**$25**
	PSA (Screening)	**$25**
	TSH	**$25**
	Vitamin D, 25-OH	**$60**
	Uric Acid	**$15**

Read and initial the following:

____ I understand that these tests are a screening tool and not designed to diagnose or predict illness. It is my responsibility to contact my physician for a professional interpretation of these results.

____ I understand that if I want a copy of these results to go to my physician that I am responsible for giving him/her a copy.

____ I understand that test results will be stored in my electronic medical record and if applicable the patient portal.

____ I understand that I must pay for these tests at the time of service.

____ I understand that my insurance cannot be billed for these tests. I will only receive a receipt of payment.

____ I understand that results will be mailed to the address I have provided within one week.

____ I have received or been offered the TVHS Joint Notice of Privacy Practices.

____ Results are confidential and in case of a critical result a provider will be notified and you will be contacted.

Signature of Participant____Date____________________

Printed Name_________________________________Relationship to Participant (if minor)____________________

TVHS Witness Signature____ Date____________________

DAT TESTING IS NOT BILLED TO INSURANCE OR MEDICARE

AMOUNT DUE___________________ PAYMENT ____Cash ____Check ____ Credit Card

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