Health Diagnostics of NWI dba

HD Discounted Labs, LLC

9003A Indianapolis Blvd. Highland, IN 46322

PATIENT:

LAST NAME:____________________________________ **FIRST NAME:**____________________________________

(CIRCLE ONE)
GENDER at BIRTH: M / F **DATE OF BIRTH:** ____________________ **TEL:** ______________________________
(Home or Cellphone number)

ADDRESS: ________________________________ **CITY:** _____________________ **STATE:**_______ **ZIP:**_______

EMAIL ADDRESS: ____

AUTHORIZATION FOR TESTING

I authorize HD Discounted Labs, LLC also dba: Health Diagnostics of NWI, LLC, to perform health testing as part of a wellness screening program or testing prescribed by my personal physician. I understand that the test results are confidential and in no way does HD Discounted Labs, LLC also dba: Health Diag-nostics of NWI, LLC, either propose, diagnose or recommend medical treatment. I further understand that it is my responsibility to contact my personal physician to follow through with my test results. I also agree & understand anything paid today is NON-REFUNDABLE.

I understand that by giving my consent, I relieve HD Discounted Labs, LLC, also dba: Health Diagnostics of NWI, LLC, and it's employees from any liabilities relating to the confidentiality of my personal test results or injury that may inadvertently be sustained during procedure. I understand that although rare, certain test(s), when positive, require additional confirmation testing as required by law to confirm result. I agree to pay for said testing immediately upon notification.

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO KNOW THE TERMS OF MY INSURANCE COVERAGE. I AGREE TO FORWARD SAID PAYMENTS IF SUBMITTED TO ME. I REQUEST ALL PAYMENTS BE MADE TO HEALTH DIAGNOSTICS OF NWI, LLC ON MY BEHALF FOR ANY SERVICES PROVIDED TO ME BY: HD DISCOUNTED LABS, LLC DBA: HEALTH DIAGNOSTICS OF NWI, LLC. I AUTHORIZE THE RELEASE OF ANY MEDICAL, NON-MEDICAL INFORMATION TO APROPRIATE AGENCIES FOR THE PROCESSING OF BENEFITS. I UNDERSTAND, SHOULD I HAVE INSURANCE, THAT I AM ULTIMATELY RESPONSIBLE FOR ANY/ALL CHARGES ICURRED AT HD DISCOUNTED LABS, LLC DBA, HEALTH DIAGNOSTICS OF NWI, LLC. I FURTHER UNDERSTAND SHOULD I DEFAULT IN PAYMENT THAT I AM RESPONSIBLE FOR ANY/ALL COLLECTION ORRNORNEY FEES INCURRED. ACCORDING TO HIPPA GUIDELINES, I ACKNOWLEDGE THAT I HAVE HAD AVAILABLE AND/ OR RECEIVED THE NOTICE OF PRIVACY PRACTICES FROM HD DISCOUNTED LABS, LLC ALSO DBA: HEALTH DIAGNOSTICS OF NWI, LLC.

DUE TO RISING COSTS, A 3.99% CONVENIENCE FEE IS ADDED TO ALL CREDIT/DEBIT CARD TRANSACTIONS. TO AVOID THIS FEE PLEASE FEEL FREE TO PAY WITH CASH OR CHECK. THANK YOU.

DATE: ________________
PATIENT and/or (GARDIAN) **SIGNATURE**: ____
(MINOR) PATIENT NAME:____

AUTHORIZATION TO RELEASE RESULTS

By signing ___________________________________, I give consent to HD Discounted Labs, LLC, dba, Health Diagnostics of NWI, LLC to disclose my test results to the following people and/or doctor offices:

______________________________, ______________________________, __________________________________