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 Health Diagnostics of NWI, LLC dba: HD Discounted Labs, LLC, to perform health testing as part of a wellness screening program, authorized by my personal physician and/or myself. I understand that the test results are confidential and in no way does Health Diagnostics of NWI, LLC dba HD Discounted Labs, 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 Health Diagnostics of NWI, LLC dba HD Discounted Labs, 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. I agree to pay for said testing immediately upon notification. Note: Any ordered test that reflex; there will be additional charges & patient agrees to pay the differences and take responsibility for any additional charges.

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 HD DISCOUNTED LABS, LLC dba HEALTH DIAGNOSTICS OF NWI, LLC ON MY BEHALF FOR ANY SERVICES PROVIDED TO ME BY: HEALTH DIAGNOSTICS OF NWI, LLC dba HD DISCOUNTED LABS, 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 HEALTH DIAGNOSTICS OF NWI, LLC dba HD DISCOUNTED LABS, 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* (GUARDIAN) **SIGNATURE**:_____
(MINOR) PATIENT NAME:_____

AUTHORIZATION TO RELEASE RESULTS

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

_____, _____, _____