HEALTH DIAGNOSTICS OF NWI DBA

# HD DISCOUNT LABS, LLC

**PRINT CLEARLY**

TODAY'S DATE:_____

LAST NAME:_____ FIRST NAME:_____

ADDRESS: _____ CITY: _____ STATE:_____ ZIP:_____

DATE OF BIRTH: _____ BIRTH GENDER: M / F PHONE:_____
**(Circle one)** (HOME OR CELLPHONE NUMBER)

E-MAIL ADDRESS (***PRINT CLEARLY***):

_____

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 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 the procedure.

I understand that although rare, certain test(s), when positive, require additional confirmation testing as required by law.

NOTE: If the test screen result is positive or equivocal (reflex), then, additional test will be performed at an extra charge.

The patient agrees to pay differences and is responsible for any additional charges.

Patient Signature: _____ DATE:_____

**By signing below, I give consent to Health Diagnostics of NWI, LLC d.b.a HD Discounted Labs, LLC to disclose my test results to the following:**

**Release results to** :

Name of DOCTOR:_____ TEL: _____ **FAX**:_____

Name of DOCTOR:_____ TEL: _____ **FAX**:_____

**TEST ORDERED:**

HD (CBC, CMP, LIPID) $50 ____

Thyroid Panel (TSH, FT4, T3F) $100____

Hemoglobin A1C $35 ____

Homocysteine $55 ____

CRP-HS (HIGH SENSITIVITY) $70 ____

PSA Total $45 ____

Magnesium $30 ____

Uric Acid $30 ____

Ferritin Panel (Iron included) $55 ____

Sedimentation rate $40 ____

Vitamin D, 25-OH $80 ____

Vitamin B12 $50 ____

Prothrombin Time (PT/INR) $40 ____

Blood Type $40 ____

Other Labs:_____

Other Labs:_____

**All Sales & services are FINAL. NON-REFUNDABLE**

**Method of Payment (CHECK ONE):**

_____CHECK _____CASH____CARD [ ____INSURANCE: service fee: _____ ]

***PRINT CLEARLY***

CARD#_____CVV:_____

EXP DATE:_____ ZIP CODE:_____

SIGNATURE:_____

***Due to rising cost, a 3.99% convenience fee is added to ALL credit card transactions.

To avoid this fee please feel free to pay with cash or check.

****Please note**: Due to rising cost: If you would like a mailed copy of the results.*

*We recommend a self addressed stamped envelope be presented during the time of service.*

_____ Mail a postage fee of $1.00 will be added to the bill

How would you like your results? **(Check all that apply)**

_____E-MAIL _____Fax the Doctor above

How did you hear about us? _____