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 (Circle one) PHONE:_____ (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, 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 Profile (CMP, CBC, LIPID)	$50	____
Thyroid Panel (TSH, FT4, T3F)	$100	____
Hemoglobin A1C	$30	____
Cortisol	$70	____
Homocysteine	$55	____
CRP-HS (HIGH SENSITIVITY)	$70	____
Lipoprotein (a)	$100	____
CK Isoenzymes (CK total included)	$90	____
PSA Total	$45	____
Magnesium	$30	____
Ferritin Panel (Iron included)	$55	____
Uric Acid	$30	____
Sedimentation rate	$40	____
Vitamin D, 25-OH	$65	____
Vitamin B-12	$50	____
Lyme Antibody	$100	____
Blood Type	$40	___
Urinalysis	$35	____

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, payment with cash or check is suggested.*

****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?_____