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)

EMAIL 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 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 test reflex; there will be additional charges & patient agrees to pay differences and take responsibility for any additional charges.

By sign-ing below, I give consent to Health Diagnostics of NWI, LLC dba HD Discounted Labs, LLC to disclose my test results to the following:

Patient Signature: _____ DATE:_____

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 $70____

PSA Total $45____

Magnesium $30____

Ferritin Panel *(Iron included)* $55____

Uric Acid $30____

Sedimentation rate $40____

Vitamin D, 25-OH $80____

Vitamin B12 $50____

Prothrombin Time (PT) $40____

Blood Type $40____

OTHER LABS:_____

All Sales & services are FINAL. NON-REFUNDABLE

Method of Payment (CHECK ONE):

_____CASH _____CHECK ____CARD ____INSURANCE

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.

What should we do with your results? (Check all that apply)

___FAX ___EMAIL ___Pick up

Please note: *due to rising cost*
If you would like a mailed copy of the results;
Please bring a pre-stamped/pre-addressed envelope during the time of service _____ Mail

How did you hear about us? _____