Health Fair

hosted by San Luis Valley HEALTH

Place form sticker here

Health Fair LABORATORY TESTING CONSENT

CONSUMER REQUEST FOR LABORATORY EVALUATION TO BE REPORTED TO PARTICIPANT ONLY (SELF-REFERRAL FOR TESTING)

Health Fair laboratory results are not sent to your physician. **You are responsible for distribution of your reports to your physician and for scheduling a follow-up appointment to discuss your results with your physician.**

PARTICIPANT INFORMATION

LAST NAME: | FIRST NAME: | MI:

DATE OF BIRTH: (MM/DD/YYYY) | # of hours fasted: | BIRTH SEX : MALE ☐ FEMALE ☐

PHONE NUMBER: | MARITAL STATUS:

MAILING ADDRESS:

CITY: | STATE: | ZIP CODE:

EMAIL ADDRESS:

RACE:
- ☐ Native American
- ☐ Native Hawaiian
- ☐ Asian
- ☐ Black
- ☐ Hispanic
- ☐ White
- ☐ Other

HISPANIC: YES ☐ NO ☐
PREFER NOT TO ANSWER ☐

	Please Check Desired Test	Price	Total
☐	Blood Chemistry (Comprehensive Metabolic Panel [**CMP**],TSH,Lipid)	$40	
☐	Complete Blood Count (CBC)	$30	
☐	Vitamin D	$55	
☐	HgA1c (Hemoglobin A1C)	$35	
☐	Blood Type (ABO/Rh)	$30	
☐	PSA (Prostate Specific Antigen) ***MEN ONLY***	$40	
☐	Iron and Iron Binding	$40	
☐	Hepatitis C	$45	
☐	Vitamin B12	$30	
☐	Ferritin	$30	
☐	Testosterone	$50	
☐	CRP	$25	
☐	FT4	$30	
☐	Colon Cancer Screening Kit	$30	
	Total	=	

How Would you prefer to receive Your Results?
Email ☐ Mail ☐

PAYMENT METHOD:
- CASH ☐
- CHECK ☐
- VOUCHER ☐
- CREDIT CARD ☐

Registration Visit ID

I agree that this test is being requested for the purpose of providing information to me, so I can compare my results with the laboratory's established reference ranges (so-called normal ranges). I understand that no medical interpretation, medical advice, or medical expertise will be provided by SLV HEALTH, Laboratory Director, staff or employees. No doctor-patient relationship exists between the Laboratory Director and me, the requestor of the tests. No doctor-patient relationship exists between the SLV HEALTH staff physicians and me, unless I have specifically scheduled a consultation with a physician who has agreed to accept the responsibility of a formal physician/patient relationship with me.
We urge all patients requesting tests for them to seek, without delay, the expertise of a health care professional skilled in the interpretation and treatment of diagnostic tests and medical conditions. It is your responsibility to seek a physician and distribute your test results to your physician.
I am 18 years of age or older and I have read, understand and agree to the above provisions.

X _____

PARTICIPANT SIGNATURE DATE

NOTICE TO ALL MEDICARE PART B BENEFICIARIES: I understand that should I go to my physician and/or healthcare provider, Medicare allows a screening occult blood test once every twelve (12) months; screening cholesterol, triglycerides and HDL tests once every five (5) years: Medicare allows 2 screening glucose tests per year for individuals diagnosed with pre-diabetes. Medicare allows 1 screening glucose test per year for individuals previously tested who were not diagnosed with pre-diabetes, or who have never been tested, and a screening Prostate Specific Antigen test (PSA) once every twelve (12) months for males who are over fifty (50) years of age.

MEDICARE WAIVER: I have been informed and understand fully, that NO claim will be filed on my behalf. NOR will I file a claim with Medicare or my Supplemental Insurance. I voluntarily take full financial responsibility for the screening(s) I have ordered, even if Medicare would have paid for any or all of these tests, had I gone to my physician or healthcare provider. I therefore, of my own will, refuse to authorize the laboratory or health fair provider of services to submit a claim to Medicare on my behalf.

_____

PARTICIPANT SIGNATURE DATE