PATIENT ACCESS TESTING
Order, Consent and Disclaimer of Liability

Name: Last ______________________________First________________________Birthdate___________ M F

Address____Phone (_______) ______________

Mark an 'X" in the boxes of the screening tests below you wish to be performed.

	Test	Price
	CBC	$20
	Glucose	$15
	Lipid panel –Fast	$25
	HA1C	$30
	PSA	$30
	Thyroid (TSH/FT4)	$30
	Testosterone	$40
	Urine Dipstick	$15
	Urine Drug Screen (8-panel)	$60
	Basic Metabolic Profile-Fast	$25
	Vitamin D (5-OH)	$40
	Men's Health Panel (BMP, CBC, Lipids, PSA) – Fast	$95
	Women's Health Panel (BMP, CBC, Lipids, Vitamin D, TSH/FT4) – Fast	$95.
	Total Due	

Registration to complete area in yellow:

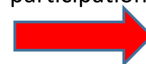
 # Tests Ordered: ______ **Amount Paid**: $_________

*I understand that if a test value is critical, I will receive a call from the hospital; however, **Sullivan County Community Hospital employees will not interpret the above test results for me.**

*I understand I will receive one copy of my test results, mailed to the address I have provided on this form.
*I am responsible for consulting a physician regarding the above test results. I will contact my primary physician for any questions or interpretations of test results.
*I am aware I should contact a physician should I start, change or stop any medications or treatment plans.
***I am aware that the above test results are for screening purposes-not a substitute for evaluation, advice, treatment or diagnosis by a physician. The results I receive are for my informational purposes only.**
*I understand the results I receive that are reported as "normal" (fall within the normal reference ranges established the above tests) do not insure wellness.
*I understand the results I receive that are reported as "abnormal" (fall outside the normal reference ranges established the above tests) may not indicate sickness or disease.

By initialing the statements below, I am acknowledging that I understand and agree to the following statements:

_____ I understand I am to pay Sullivan County Community Hospital for the above tests in full at the time of service. (**There is no refund option and I will receive no further billing.)**
_____ I understand the hospital **will not submit** these tests for payment to my insurance or Medicare.
_____ I understand these tests will not be included in my electronic medical record.
_____ I understand my results will be mailed to me at the address provided above. I accept all responsibility should someone at that address other than myself see these test results.
_____
_____ I understand I must provide a telephone number where I can be reached should any of my results fall in the critical range.
_____ I assume all responsibility and risk of ordering tests without active participation from a physician. I will not hold Sullivan County Community Hospital, its employees or agents liable for any outcomes that may occur from my voluntary participation in this laboratory testing.



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I have read and understand the information provided to me in this disclaimer and I hereby authorize Sullivan County Community Hospital to complete the screening laboratory tests I have requested.

Signature____ Date__________________

Witness____ Date__________________

LAB USE ONLY:
Mail Date: INITIALS: