MCH SELF-DIRECT CASH PAY LAB – ORDER FORM

Name: _____ Date of Birth_____ ** **M** **F** (circle)

Address: _____
Street Address/PO Box Number, Apartment # City State Zip Code

Phone Number: _____

****Provider(s)**: _____ or **Unassigned** (circle if no Provider)

If a provider(s) is listed then results will be sent to the provider(s). If a provider is not listed then the patient will be responsible for results. Results will be available for you (or designee) at the lab. If you would like them mailed please let us know so we can have you fill out a self-addressed envelope. Note: you must have a lab authorization release form filled out within the last 12 months to have results mailed or picked up in lab. You do not need a result authorization release form if the results are being sent directly to your provider(s). If no provider is given then critical results will be reported to your primary provider on file or the on-call ER provider at MCH, who should then contact you regarding the result. ** Non-Diagnostic Use Only **

**Result Authorization signed within last year? Yes / No (circle)

**Result delivery: In-lab pickup / Mailed or Sent to Provider(s) (circle)

PLEASE CHECK THE LAB TESTS YOU WANT DONE. ** Fasting? Yes / No (circle)

❑ **CBC**- complete blood count w/ platelets	**$20**
❑ **Lipid Profile -** cholesterol/triglycerides/HDL **(**8 hours fasting)	**$20**
❑ **Comprehensive metabolic Panel** - Chem14	**$25**
❑ **Hgb A1C -** diabetes	**$30**
❑ **PSA –** prostate specific antigen	**$30**
❑ **TSH –** thyroid stimulating hormone	**$30**
❑ **ABO/RH –** blood typing	**$30**
❑ **Testosterone –** checks hormone level	**$30**
❑ **Venipuncture –** draw fee	**$5**

Paid by: ❑ Check ❑ Cash ❑ Debit/CC Total _____ Receipt ❑

Must be 100% paid in full before patient collection. There will be no billing done to individual insurance companies, Medicare, or Medicaid for these tests. Once collected and performed, tests cannot be changed back to bill insurance. Insurance billable tests cannot be performed or added to the same day of service tests performed through direct access.

****Patient Signature _____ **Date** _____

Below to be filled out by specimen collecting personnel:

Collection Date: ____/____/____Time: ____:____Collected by _____ FIN #_____

(2/14/23)