Community Hospital Anderson

Affix patient label here.

Wellness for You

Please read and initial at each statement:

_____ I consent to the laboratory procedure that is being performed on an outpatient basis today.

_____ I understand that I will be notified personally of critical values that need immediate attention. I will then be responsible for contacting my physician or seeking medical follow up care.

_____ I understand that results are to be mailed to me within 5 working days.

_____ I understand that if I want a copy of these results to go to my doctor, I am responsible for giving him/her a copy.

_____ I understand that I cannot bill my insurance for this testing, and I will not receive a bill for this service, only a receipt of payment.

_____ I have received or been offered the Notice of Privacy Practices.

_____ _____

Customer signature *Date* *Witness* *Date*

_____

Parent / Guardian / Representative Signature *Date*

X	Price	Test	X	Price	Test
	$15	ALT / SGPT		$40	Testosterone
	$15	AST / SGOT		$30	Thyroid Stimulating Hormone
	$20	Blood Type (ABO/RH)		$10	Urinalysis (U/A)
	$20	BMP (Basic Metabolic Panel)		$33	Urine Drug Screen (without confirmation)
	$20	CBC (Complete Blood Count)		$51	Vitamin D Hydroxy 25 Total
	$25	CMP (Complete Metabolic Panel)		$75	Vitamin B12 and Folate
	$10	Glucose		$125	**Immunization Confirmation Profile** (Rubella, Rubeola, HBSAb, Varicella IgG, Mumps)
	$25	Hemoglobin A1c		$25	Rubella
	$25	Lipid Panel		$25	Rubeola
	$25	Immunochemical Fecal Occult Blood		$25	HBSAb
	$25	Free T4 (Free Thyroxine)		$25	Varicella IgG
	$20	Pregnancy Test (Serum)		$25	Mumps
	$35	Prostate Specific Antigen (PSA)			

4/2016
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