WH0564LAB
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Previous Edition Is Obsolete

PATIENT SELF-DIRECTED LABORATORY TESTING ORDER/CONSENT FORM

Wayne HealthCare • 835 Sweitzer Street • Greenville, Ohio 45331

Name (PLEASE PRINT): _____ Sex: ☐ Female ☐ Male
LAST FIRST MIDDLE INITIAL

Date of Birth: _____/_____/_____ (MUST BE 18 OR OLDER OR HAVE GUARDIAN PRESENT TO PARTICIPATE)
MONTH DAY YEAR

Address: _____ Home Phone: _____

_____ Cell Phone: _____

Email Address (REQUIRED FOR PATIENT TEST RESULT PORTAL ACCESS): _____

Emergency Contact and Telephone Number: _____

I hereby grant permission to Wayne HealthCare Laboratory (the "Lab") to perform certain screening tests as set forth below at my direction, which may include obtaining specimens of blood by venipuncture or finger stick. I authorize the Lab to obtain these screening results and mail them to me at the above address. I agree to pay for the tests in full at the time of service.

I understand that the testing has not been ordered by a physician and is being done for my own use and not for medical diagnostic or treatment purposes. Because the tests are not ordered by a physician, insurance coverage is not available, including Medicare or Medicaid. The Lab will not submit the tests to any insurance company for reimbursement.

I further understand that the test results will not be forwarded to any medical professional for diagnosis of any medical condition. If testing returns critical values which may indicate a serious medical condition, the Lab will make reasonable attempts to notify me promptly, including by telephone and by leaving voicemail. If the Lab is unable to reach me, I give permission to contact the emergency contact listed above to report the critical values.

It is my responsibility to share the test results with my physician at my sole option. I alone am responsible for obtaining medical information, treatment or services from a doctor or other health care provider in relation to the test results.

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE ACKNOWLEDGEMENT AND HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENTS. BY SIGNING BELOW, I CONSENT TO UNDERGO THE SELF-DIRECTED LABORATORY TESTING UNDER THE CONDITIONS SET FORTH HEREIN.

	PANEL	PRICE		PANEL	PRICE
☐	Wellness Panel Fasting (CMP & Lipid) *	$50.00	☐	Liver Panel (In Wellness Panel)	$30.00
☐	Vitamin D	$60.00	☐	Lipid Panel (In Wellness Panel)*	$35.00
☐	Complete Blood Count & Diff	$30.00	☐	Cholesterol (In Wellness Panel)	$20.00
☐	Hemoglobin A1C	$30.00	☐	Glucose Fasting (In Wellness Panel)*	$15.00
☐	Thyroid Panel (TSH/FT4)	$45.00	☐	Potassium (In Wellness Panel)	$15.00
☐	PSA Screen	$45.00	☐	Basic Met Panel/BMP (In Wellness Panel)*	$30.00
☐	Iron	$20.00	☐	Urine Pregnancy Test	$15.00
☐	COVID-19 Rapid PCR	$100.00	☐	COVID-19 IgG Antibody	$65.00

*Fasting Required. Do not eat or drink anything, except water, for 8-12 hours prior to blood collection. Consult your physician before stopping any medications.

TOTAL DUE: $_____ **PAID:** Cash: $_____ Check #: _____ Credit Card: _____ Rec'd by: _____

Collection Date: _____/_____/_____ Collection Time: _____: _____ Phleb Initials: _____

_____
PATIENT'S SIGNATURE (LEGAL GUARDIAN SIGNATURE IF PARTICIPANT IS UNDER 18 YEARS OF AGE)

_____
PRINTED NAME & RELATIONSHIP TO PATIENT, IF SIGNING ON THE PATIENT'S BEHALF (GUARDIAN)

_____
DATE

PATIENT LABEL