Minidoka Memorial Hospital

Laboratory Wellness Screening for Patient-Initiated *(Direct Access)* Testing

****REVISED 07/17/2020****

Dear Patient: Please be aware that State regulatory requirements regarding patient-initiated testing do not allow us to send your lab results to your family healthcare provider. **Due to the regulatory requirements, only the provider signing below will receive lab results.** The provider signing this form may contact you regarding critical values outside of the standard range.

The laboratory tests that you are having performed today fall under a special category and are subject to the following conditions:

- **Payment *(cash / personal check / credit card)* is required at the time of service.**
- **Insurance companies, Medicare, and Medicaid do not accept billing for patient-initiated testing; therefore, Minidoka Memorial Hospital does not bill – or provide billing information – for patient-initiated testing.**
- **A copy of your lab results will be mailed to the address you provide below.**

1. _____**(Patient Initials)** A *Notice of Privacy* practices has been made available to me.
2. As the patient, you are responsible to consult a physician for interpretation and care if results are abnormal.
3. As the patient, you are responsible to consult a physician for further care if the test results are normal and symptoms continue.
4. As the patient, you are responsible to follow-up with a medical provider for diagnosis and treatment.

I have read and understand the above statements and consent to have my blood drawn. I have had the opportunity to ask questions and understand the answers provided to my questions.

Signature:_____Date:_____

Last Name:_____First Name:_____Middle Initial:_____

Mailing Address:_____City:_____State:_____Zip:_____

Phone:_____Date of Birth:_____Gender:_____

Family Healthcare Provider:

Provider Signature:_____ Date:

ONLY THE FOLLOWING LABS ARE ALLOWED FOR PATIENT-INITIATED TESTING

**** 12-14 hour fast required for these tests. You may drink - water only - for ** tests.**

Mark Test(s) to be Performed	Name of Lab Test	Cost
	Complete Blood Count *(CBC with auto differential)*	$ 15.00
	**Comprehensive Metabolic Panel *(blood sugar, liver, kidney, electrolytes)*	$ 25.00
	ESR- *(sedimentation rate)*	$ 10.00
	Ferritin	$ 15.00
	**General Health Panel *(comprehensive metabolic panel, Lipid, CBC and TSH)*	$ 80.00
	Glycohemoglobin (A1c)	$ 25.00
	Hemosure-Fecal occult blood test *(sample collection kit)*	$ 10.00
	Iron/ IBC	$ 35.00
	**Lipid *(cholesterol HDL, LDL, VLDL, calculated risk and triglycerides)*	$ 20.00

	Pregnancy Test, Qualitative *(urine or serum)*	$ 15.50
	Prostate Specific Antigen *(PSA)*	$ 15.00
	Protime / INR	$ 25.00
	Thyroid Stimulating Hormone *(TSH)*	$ 20.00
	Thyroid- Free T4	$ 20.00
	Uric Acid	$ 10.00
	Urinalysis *(dipstick only)*	$ 25.00
	Vitamin D-25, Hydroxy	$ 50.00
	Venipuncture	$ 7.00

METHOD OF PAYMENT (circle one): CASH PERSONAL CHECK CREDIT CARD TOTAL DUE $_____

PATIENT LABEL

Processing Laboratory Personnel

Initial here: _____