

Health Fair Registration Form

Dear Patient: Due to State regulatory requirements, we are unable to provide your lab results to your family healthcare provider. Only the provider signing below will be sent lab results. The provider signing this form may contact you regarding critical values outside of the standard range.

** Indicates a required field.*

*Last Name: *First Name: *Middle Initial:

*Date of Birth: *Phone Number: Last 4 numbers of SSN:

*Address: *City: *State:

*Gender: *Zip Code:

***PLEASE SELECT THE TESTS DESIRED:**

- \$60.00 Health Fair Profile
- \$25.00 Total Testosterone
- \$15.00 PSA Test (Men only)
- \$30.00 Glycohemoglobin (A1C)
- \$50.00 Vitamin D-25OH

TOTAL

Provider Signature: _____

Date: _____

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

- Payment (*cash/personnel check/credit card*) is required at the time of service.
- Insurance companies, Medicare, and Medicaid **DO NOT** accept billing for patient initiated testing, which includes health fairs; 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 on this form.



Minidoka Memorial Hospital
1224 8th Street
Rupert, ID 83350

HEALTH FAIR RECEIPT

Name:

Birth Date:

Tests performed:

- Health Fair Profile: \$60.00
- Total Testosterone: \$25.00
- PSA (Men only): \$15.00
- Glycohemoglobin (A1C): \$30.00
- Vitamin D-25OH: \$50.00

Total Due:

Received by:

Date:

Not valid after last day of health fair

Print Form