Minidoka Memorial Hospital

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

Dear Patient: While we will be faxing the results of this lab testing to the provider whose signature appears on the order, we encourage you to communicate with them directly or your family healthcare provider regarding your test results.

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. _____**(Initial)** A *Notice of Privacy* practices has been disclosed to me.
2. You are responsible to consult a physician for interpretation and care if results are abnormal.
3. You are responsible to consult a physician for further care if the test results are normal and symptoms continue.
4. 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:

Physician 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)	$ 20.00
	**Comprehensive Metabolic Panel (Blood Sugar, Liver, Kidney, Electrolytes)	$ 30.00
	ESR- (Sedimentation Rate)	$ 10.00
	Ferritin	$ 15.00
	**General Health Panel (Comprehensive metabolic panel, Lipid, CBC and TSH)	$ 90.00
	Glycohemoglobin (A1c)	$ 30.00
	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
X	Venipuncture	$ 7.00

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

PATIENT LABEL

Processing Laboratory Personnel
Initials: _____