DIRECT TO CONSUMER TESTING CONSENT FORM

By voluntarily participating in this testing, I recognize and accept all risks associated with the Direct to Consumer program. I understand the results of the blood tests do not constitute a complete medical examination or diagnosis. For diagnosis of a medical problem, I must see a provider for a complete medical examination.

I understand that a physician's order is not required for this testing today.

I also understand that it is my responsibility to pay in full for this testing at the time of service.

Direct to Consumer Testing is not reimbursed by any health insurance company or by Medicare, Medicaid or any other city, state, or federal programs. You may not submit a request for payment or reimbursement of the charges from Direct to Consumer Testing to any health insurance company or to Medicare, Medicaid, or any other city, state, or federal program. [INSERT FACILITY NAME] will not bill your insurance company for this service.

I hereby release [INSERT FACILITY NAME], the medical staff, and any other organization involved in this testing, and their agents from all liabilities, medical claims, or expenses that may arise from my participation or any injury sustained during this testing. **I understand it is my responsibility to share test results with my provider.**

When testing is completed a copy of your tests will be mailed to you. Infrequently, results of tests are sufficiently abnormal or critical that [Lab] may need to contact you immediately so you can make a decision on seeking medical care [INSERT FACILITY NAME] Laboratory Services strongly recommends you consult with your provider for proper interpretation of test results. If you have any questions regarding our services, please call [FACILITY PHONE NUMBER]. If you do not have a provider, please go to mercy.com/find a doctor.

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I have read this form and understand its contents. I understand the results will be released to me and [INSERT FACILTY NAME] will maintain the confidentiality of the test results.

If receiving HIV testing, results will be reported to the State Department of Health as required by law.

I also allow [INSERT FACILITY NAME] to contact me at a later date regarding this testing.

[Facility Name] can leave a message on my voicemail. __________**YES** __________**NO**

ALL DATA LISTED BELOW IS REQUIRED IN ORDER TO PERFORM TESTING.

X________________________________ ____________________

PATIENT SIGNATURE (if under 18, guardian signature) Date

PLEASE PRINT PATIENT INFORMATION:

Name: ____

Address: ____

City/State/Zip: ____

Date of birth: ____

Gender: ____

Phone number: ____

Emergency phone number: ____

Social Security Number: ____

(By providing your ssn, you are giving permission to allow your results to go back to MyChart and your electronic medical record)