Mercer Health
800 W. Main St. ~ Coldwater, OH 45828

Clinical Laboratory - Patient Authorized Direct Access Testing

Participant's Last Name	Legal Name	MI	Date of Birth	Sex M F

Address	City	State	Zip	Email Address

Phone #	Cell #	Marital Status	Race	Ethnicity
Emergency Contact		Phone #	Relationship	
Emergency Contact Address				

- I hereby request and grant permission to Mercer Health Laboratory to perform certain screening tests as set forth below, which may include obtaining specimens by venipuncture or finger stick. I request and authorize Mercer Health Laboratory to obtain these screening results and **mail them to me at the above address.**
- I also understand that this **testing should NOT be used as the only means to diagnose the existence or absence of any medical condition.** I understand that the Laboratory test results may be normal in presence of certain disease states. I understand that I alone am responsible for obtaining medical information or services from a doctor or other qualified health care provider.
- I understand that it is **my responsibility to send or share this information with my personal physician**, Mercer Health Laboratory is not proposing diagnosis or recommending medical treatment, but is merely acting as a resource to provide this additional, medical information. I understand that should I become ill, have any complaints, or have any questions regarding my health; it is my responsibility to contact my physician.
- I understand that these test results **will be included in the complete medical record** chart kept at Mercer Health and may be viewable by my health care provider.
- I am releasing all agents, employees, and volunteer personnel involved in this health screening from any and all liability for the results of the testing/screening or any treatment I may receive from a physician of my choice based upon the information provided by this program.
- **I understand that up to 25% of prostate cancers will be missed by a PSA screening only**. PSA testing **should be accompanied by a digital rectal examination**, which is only part of a regular examination. It is **highly recommended that you see your personal physician for this service.**
- I understand that because the tests are not ordered by a physician, **insurance companies routinely do not cover the tests**. I understand that Mercer Health will NOT submit these tests for insurance reimbursement.
- I understand that Mercer Health has a policy in place to test patients and participants of this testing program for Hepatitis and Human Immunodeficiency Virus, in the event an employee sustains an exposure to a patient's or participant's blood or body fluid specimen. In the event of such exposure, I hereby consent to such testing by Mercer Health; the results of which will also be provided to me.

I have read, understand and agree to the above provisions:

Participants Signature_____Date_____

(Legal Guardian signature if Participant is under 18 years of age)

_____$45.00 **Comprehensive Metabolic Panel** (CMP) (CPT 80053)

_____$30.00 **Basic Metabolic Panel** (BMP) CPT 80048) *all included in CMP*

_____$35.00 **Kidney Panel** (CPT 80069) *some tests included in CMP*

_____$35.00 **Liver Panel** (CPT 80076) *some tests included in CMP*

_____$50.00 **Thyroid Panel** includes TSH and free T4(CPT 84443; 84439)

_____$25.00 **TSH** (CPT 84443)

_____$15.00 **Glucose** (CPT 82947) *inc. in CMP, BMP, Kidney panel*

_____$15.00 **Potassium** (CPT 84132*) inc. in CMP, BMP, Kidney panel*

_____$25.00 **Lipid Profile** (CPT 80061)

_____$45.00 **PSA Screen** (CPT G0103)

_____$25.00 **Hemoglobin A1C** (CPT 83036)

_____$15.00 **ABO/Rh** (CPT 86900; 86901)

_____$20.00 **CBC with diff** (CPT auto:85025)

_____$15.00 **Cholesterol** (CPT82465) *inc. in Lipid Profile*

_____$40.00 **Vitamin D** (CPT 82306)

_____$30.00 **Testosterone, Total** (CPT 84403)

$_____Total Due Paid: Cash_____ Check #_____ Credit Card_____ Rec'd by_____

**Checks Payable to Mercer Health Tax ID# 34-1101385

LAB USE: Location: Hospital / CPH/STH-FTR/SL (circle one) Collection Date / / Collection Time : Phleb. Inititals:

Form #86 Updated: 08/2018