ANYLABTEST NOW

CUSTOMER INFORMATION

NAME _____ DATE OF BIRTH (MM/DD/YYYY) _____

ADDRESS _____ CITY _____ STATE _____ ZIP CODE _____

PHONE NUMBER _____ PHONE NUMBER _____

EMAIL ADDRESS _____ MALE ☐ FEMALE ☐

☐ NO! DO NOT SEND ME ANY LAB TEST NOW INFO, PROMOS, ETC. VIA EMAIL

ARE YOU WILLING TO RATE YOUR SERVICE IF WE SEND YOU AN SMS OR EMAIL? YES ☐ NO ☐

ALLERGY INFORMATION (CHECK ALL THAT APPLY)

☐ LATEX ☐ ALCOHOL ☐ BETADINE ☐ OTHER (PLEASE SPECIFY) _____

HOW DID YOU HEAR ABOUT US?

☐ INTERNET ☐ RADIO/TV ☐ PRINT AD ☐ DIRECT MAIL ☐ WALK/DRIVE-BY ☐ SOCIAL MEDIA

☐ PROFESSIONAL REFERRAL ☐ PERSONAL REFERRAL ☐ OTHER _____

SELECTED TESTS OR PANELS

	$
	$
	$
	$
TOTAL	$

CUSTOMER'S PREFERRED METHOD OF RECEIVING RESULTS

☐ EMAIL ☐ U.S. MAIL ☐ PICK-UP ☐ FAX

CUSTOMER HAS READ AND SIGNED AFFIXED EMAIL AUTHORIZATION FORM. YES ☐ NO ☐

DO YOU WANT US TO FAX A COPY TO YOUR DOCTOR'S OFFICE?
YES ☐ NO ☐ CALL ME FIRST WHEN RESULTS ARE READY ☐

DOCTOR'S NAME _____ DOCTOR'S OFFICE FAX NUMBER _____

SPECIAL INSTRUCTIONS _____

SIGN RELEASE AND CONSENT FORM (OVER)

ANYLABTEST NOW

CUSTOMER INFORMATION RELEASE AND CONSENT FORM

_____ INITIAL I understand that test results reported by ANY LAB TEST NOW will be reported directly to me, in the manner chosen below. I further understand that it is my responsibility to consult my own medical doctor for interpretation, analysis, evaluation, and explanation of my test results. I understand that neither ANY LAB TEST NOW nor its ordering physician will analyze, evaluate, critique or otherwise interpret the results of said tests. I agree that ANY LAB TEST NOW, its officers, shareholders, directors, employed physicians, or its other agent or employee shall not be liable for any claims including, but not limited to, any claim arising out of or related to, inaccurate, uninterrupted, misinterpreted or results not received and do hereby expressly forever release and discharge all claims, demands, injuries, damage, actions or causes of action.

_____ INITIAL I certify that I will not seek to be reimbursed by Medicare, Medicaid, Tricare or any other government insurer/payer. I agree that I am personally financially responsible for payment of fees for all tests ordered and collected by ANY LAB TEST NOW at my request.

_____ INITIAL I understand that the laboratory tests performed at ANY LAB TEST NOW are done at my request. I further understand that a physician employee of ANY LAB TEST NOW who is licensed under state law to order such testing will do so. I also understand that ANY LAB TEST NOW is a collection facility and that the actual testing will be performed by a third party laboratory, certified to perform such testing on the specimens collected by ANY LAB TEST NOW. I understand and agree that ANY LAB TEST NOW will report the results of the testing directly to me, my physician, or any health professional I request. I consent and authorize that such disclosure may be made by fax, by mail or by direct pick-up. I understand and agree that the services provided by ANY LAB TEST NOW and the test results from the lab will be maintained as confidential, protected health information by ANY LAB TEST NOW as required by federal and state law.

_____ INITIAL I understand that the test results may become part of my medical record. I also understand that an insurance company may discover the results of this testing by obtaining a copy of my medical record in accordance with the terms of my insurance policy(ies). I hereby consent to the release of my laboratory test results by ANY LAB TEST NOW to me in the manner I have chosen below and my physician or any other healthcare provider I designate. I understand that my test results will only be provided to other third parties upon my express consent.

_____ INITIAL I understand services are paid for at the time that services are performed. No refunds or chargebacks will be accepted.

_____ INITIAL All of the above has been discussed with me and I have had an opportunity to have any questions answered that I may have regarding my rights to privacy by an employee of ANY LAB TEST NOW. I have received a copy of Notice of Privacy Practices, as required by HIPAA from ANY LAB TEST NOW or I have chosen not to receive a copy.

_____ INITIAL I have read and agreed to all the above terms.

_____ _____

CUSTOMER SIGNATURE DATE

CUSTOMER PICKED UP VIA:

☐ EMAIL ☐ U.S. MAIL ☐ PICK-UP ☐ FAX

LAB REQUISITION NUMBER _____

CUSTOMER RECEIVED TEST RESULTS ON (MM/DD/YYYY) ____/____/_____ VIA METHOD CHOSEN ABOVE

CUSTOMER RECEIPT NOTES _____