Information on this form is used by The Hereditary Cancer Foundation for metric Purposes only! Data is NEVER SOLD or SHARED outside The Hereditary Cancer Foundation, the LAB performing your test or your Healthcare Provider.

Once you have COMPLETED this form, a member of the Foundation and the Board will look at the information and contact you if there is any additional need. If you have questions in the meantime, please reach out to us via email at financial@hereditarycancer.org

Full Name: _____

Date of Birth: ____/____/____ Gender:_____ Race/Ethnicity: _____

Address: _____

City:_____ State: _____ Zip: _____

Email: _____

Phone Number: _____

Do you have a Personal History of Cancer? (please circle one) Yes No

Do you have a FAMILY history of cancer? If so, Please provide below. (Specific Relation and age at diagnosis)

_____

_____

_____

_____

_____

TESTING INFORMATION:

Have you submitted your testing sample yet? Yes No

If yes, what was the date of submission? _____/_____/_____

Provider Name: _____

FINANCIAL DETERMINATION QUESTIONS:

Please Check the box that best answers the following questions:

Your Yearly Income

- ☐ Less than $20,000
- ☐ $20,000 to $35,000
- ☐ $36,000 to $50,000
- ☐ $51,000 to $75,000
- ☐ $76,000 to $100,000
- ☐ More than $100,000

Family Size

- ☐ 1
- ☐ 2
- ☐ 3
- ☐ 4
- ☐ 5
- ☐ 6
- ☐ 7
- ☐ 8
- ☐ 9
- ☐ 10+

Consents and Acknowledgements:

- ☐ I am aware that the information on this form is used by The Hereditary Cancer Foundation for metric Purposes only! Data is NEVER SOLD or SHARED outside The Hereditary Cancer Foundation, the LAB performing your test or your Healthcare Provider.

- ☐ I agree to allow the Kamie K Preston Hereditary Cancer Foundation to release genetic testing results from my healthcare provider and for my provider to release any additional information needed to process the funding to the Kamie K Preston Hereditary Cancer Foundation.

Patient Signature: _____ Date:_____

RELEASE OF INFORMATION

I, (patient name) _____, agree to release my cancer genetic testing results from (practice) _____ to the Hereditary Cancer Foundation. I understand my results will only be used for the Hereditary Cancer Foundation's metric keeping and my results or identifying personal information will not be shared.

Patient Signature: _____

Date: _____

Provider Office Notes:

Please Email **financial@hereditarycancer.org** with the following information if you have

- ☐ Your Contact Information
- ☐ Patient's personal or family cancer history or what qualifies them for genetic testing
- ☐ Copy of signed Release of information from patient
- ☐ Copy of Bill or link to pay online