SELF-PAY LAB WORK

Monitor your health without the hassle of insurance companies!

PLEASE PRINT CLEARLY

Last Name:_____ First Name:_____ Date of Birth:_____

Address:_____ ☐ Male ☐ Female

City:_____ State:_____ ZIP:_____ Have you fasted? ☐ Yes ☐ No

Telephone:_____ Email:_____

Primary Care Physician (PCP):_____

Do you want a copy of your lab report sent to your PCP?

☐ Yes ☐ No

TruChoice Diagnostics, LLC

WELLNESS PANEL

☐ $50 Includes tests with

☐ **BMP** $12
BUN, calcium, carbon dioxide, chloride, creatinine, glucose, potassium, and sodium

☐ **Hepatic Panel** $12
Total protein, albumin, ALT and AST

BMP & Hepatic Panel = CMP

☐ **CBC** $12
Complete Blood Count

☐ **Lipid Panel** $12
Total cholesterol, HDL, LDL, and triglycerides

☐ **Renal Panel** $12
BUN, creatinine, glucose, calcium, albumin, and phosphorus

☐ AFP	$50
☐ Vitamin D	$50
☐ PTH, Intact	$30
☐ PSA	$30
☐ Hemoglobin A1C	$25
☐ Iron, TIBC, % Sat.	$20
☐ TSH	$20
☐ TT3	$15
☐ TT4	$15
☐ FT4	$15
☐ GGT	$15
☐ Ferritin	$15
☐ Microalbumin	$15
☐ Urinalysis	$15
☐ CK	$12
☐ Uric Acid	$12
☐ Magnesium	$12
☐ Sed Rate (ESR)	$12

☐ Flu Vaccination

☐ **COVID Rapid** $75
SARS-CoV-2 Rapid Antigen

☐ **Flu Rapid** $75
Flu A / Flu B Rapid Antigen

☐ **COVID / FLU / RSV** $150
COVID / FLU / RSV RT-PCR

☐ **CT / NG*** $100
Gonorrhea / Chlamydia RT-PCR

☐ **HIV Screen*** $50

☐ **Syphilis Screen*** $50

☐ **MONO Screen** $20

☐ **Rapid Strep*** $20

☐ **HCG, Qual** $15

*Verbal consent from PCP or Ordering Doctor required for tests with **

TruChoice Diagnostics
135 Midway Drive, Suite A
Dubois, PA 15801
Mon-Thurs 7:00am - 4:30pm
Friday 7:00am - 1:00pm
Phone: (814) 200-9791
Fax: (814) 503-8112
www.truchoice.org

More Tests Available on Request

Attending Provider Signature: Date:

TruChoice Diagnostics, LLC

Attending Provider Agreement

Name:_____ DOB:_____

Primary Care Physician:_____

Consent for treatment/payment:

This is to certify that I consent to and authorize the performance of specimen collection and analysis of the chosen laboratory panels.

TruChoice Diagnostics, LLC cannot perform laboratory testing for patients who do not have a primary care physician. A primary care physician must be provided upon registration in the event that the attending provider for TruChoice Diagnostics, LLC needs to reach them in regards to any critical results. I understand that the attending provider will not follow up with me or my primary care physician regarding my lab testing or results. It is the responsibility of the patient to obtain results and seek interpretation, counsel or treatment.

I agree to take full financial responsibility for the cost of the tests that I request and payment must be rendered prior to specimen collection.

Patient Signature: _____ Date: _____

Patient's First Name: _____ Patient's Last Name:_____ DOB:_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

1. I understand that this authorization will expire 1 year from the signature date
2. I understand that I may revoke this authorization prior to the release of results
3. I understand that I can refuse to sign and my service or care will not be affected
4. I may inspect or copy any information used or disclosed under this agreement
5. I authorize the release of medical information to other physicians and/or facilities involved in my health care.
6. I understand that if the person or organization that received the information is not a health care provider, the information described above may be redisclosed and would no longer be protected under these regulations.

I voluntarily authorize the disclosure of information from my health record to myself and other entities involved in my care.

×Signature:_____ **Date:**_____

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You have the right to inspect and copy your own health care information, and that of an individual of whom you are a legal guardian or next of kin. Please provide the necessary information to access your lab results or simply decline this service below.

☐ I **DECLINE** access to my own lab results

OR

☐ **PORTAL ACCESS**: Please provide your e-mail address to receive a registration code to view all of your lab results online through our secure patient portal

E-MAIL:_____

☐ **MAIL RESULTS:** Receive results at your mailing address on file within 2 weeks of result completion.
This service costs $2.00 as the time of specimen collection

☐ I am next of kin requesting on behalf of the patient and our relationship is:

_____