

# SELF-PAY LAB WORK

Monitor your health without the hassle of insurance companies!

PLEASE PRINT CLEARLY

Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ Have you fasted? Yes [ ] No [ ]

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ Are you diabetic? Yes [ ] No [ ]

Telephone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Gender Identification: (Identify) \_\_\_\_\_

Primary Care Physician (PCP): \_\_\_\_\_



## \*CHECK REQUESTED TESTS BELOW\*

### SPECIALTY

- PSA** **\$30**  
Prostate Specific Antigen, often used to diagnose prostate cancer
- Vitamin D** **\$50**  
Used to diagnose Vitamin D deficiency  
*\*Low Vitamin D levels can cause fatigue and insomnia*
- Hemoglobin A1C** **\$25**  
Measures the amount of blood sugar (glucose) attached to hemoglobin
- Microalbumin** **\$15**  
Quantitative analysis of the amount of albumin in random urine
- Ferritin** **\$15**  
Measures stored iron in the body, often used to diagnose Anemia
- Iron Profile** **\$25**  
Used to diagnose iron deficiency / anemia. Includes iron, total iron binding capacity, % saturation, and ferritin
- PTH** **\$30**  
Measures the level of parathyroid hormone in blood
- TSH** **\$20**  
Measures the function of thyroid gland (hyper / hypo active)
- TT3** **\$15**
- FT4** **\$15**

### WELLNESS PANEL

- \$50 Includes tests with**
- Basic Metabolic Panel** **\$12**  
 Measures the blood levels of urea, nitrogen, calcium, carbon dioxide, chloride, creatinine, glucose, potassium, and sodium
- Hepatic Panel** **\$12**  
 Measures the function of your liver (total protein, albumin, ALT and AST)  
*\*BMP & Hepatic Panel is CMP\**
- CBC** **\$12**  
 Complete Blood Count, evaluates the cells that circulate in blood
- Lipid Panel** **\$12**  
 Measures the good cholesterol (HDL), bad cholesterol (LDL), and triglycerides  
*\*Good assessment of heart health*
- Renal Panel** **\$12**  
 Helps determine kidney function by electrolytes, BUN, creatinine, glucose, calcium, albumin, and phosphorus

**\$125 POST COVID-19 INFECTION PANEL**  
*\*CBC, BMP, Liver Panel, Urinalysis, Ferritin, TSH, FT4, Vitamin D, Sed Rate\**

### OTHER

- Urinalysis** **\$15**  
Used to diagnose urinary tract infections, kidney / liver disorders, diabetes, and metabolic conditions
- COVID Rapid** **\$100**  
SARS-CoV-2 Rapid Antigen
- Flu Rapid** **\$75**  
Flu A / Flu B Rapid Antigen
- COVID PCR** **\$200**  
COVID / FLU / RSV RT-PCR
- STD Screen** **\$100**  
Gonorrhea and Chlamydia
- Sed Rate (ESR)** **\$10**
- MONO Screen** **\$20**
- HIV Screen** **\$50**
- Rapid Strep** **\$20**
- Pregnancy Test** **\$15**
- Serum Analytes** **\$10 ea.**
  - Iron (Fe)
  - Magnesium (Mg)
  - Uric Acid (UA)
  - Creatine Kinase (CK)
  - Gamma-glutamyl transferase (GGT)
  - Potassium (K)
  - Total Protein (TP)

**\*More Tests Available on Request\***

Attending Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_

# TruChoice Diagnostics, LLC

## Attending Provider Agreement

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

PCP: \_\_\_\_\_

**Please indicate how you would like to receive a copy of your results.**

Mail \_\_\_\_\_

Fax \_\_\_\_\_

E-Mail \_\_\_\_\_

*For your privacy, E-Mailed result reports are password protected. To view/download the PDF, you must enter a password.*

**PASSWORD: Patient's DOB in MMDDYYYY format**

Don't include: Hyphens(-), Slashes(/), or spaces) when entering your password

**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 who your labs are ordered under 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 results unless there is a critical value and it is my responsibility to obtain my results and seek interpretation, counsel, or treatment.

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

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_