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 (blood drop)

- ☐ **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:_______________

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: _____________

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To receive a copy of your lab results please complete the form and sign below.

1) I,___________________________________ hereby voluntarily authorize the disclosure of Laboratory Results from my health record.

RESULT RETRIEVAL:

Please select the preferred method for result retrieval and provide the information necessary

☐ **E-MAIL ADDRESS: ____**

*****FOR YOUR PRIVACY EMAILED RESULTS ARE PASSWORD PROTECTED. THE PASSWORD TO VIEW YOUR RESULTS IS YOUR BIRTHDATE IN (MM/DD/YYYY) FORMAT.*****

☐ **MAILING ADDRESS:____**

☐ **FAX NUMBER:____**

1. I understand that this authorization will expire 30 days from this 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 this authorization and this refusal will not affect my ability to obtain service
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 healthcare provider, the information described above may be redisclosed and would no longer be protected under these regulations.

Signature:____ Date:_________________