# Clinical Laboratory—Patient Authorized Direct Access Testing

**Patient Name** ______________________________________________**D.O.B.** _____/_____/______

**Address**______________________________**City** _______________________**State** ______________

**Zip Code** _____________________________ **Phone**_________________________________________

*Gothenburg Health (GH) is pleased to offer Lab Direct Access Testing (DAT) to our patient population. Patients who are uninsured, have a health savings account, have a high deductible, or who don't want to file a claim to their insurance may request these tests at a low out-of-pocket expense. Please review the following:*

- I request & grant permission to GH Lab to perform screening tests as set forth below, which may include obtaining specimens by venipuncture or finger stick. I request & authorize GH Lab to obtain these screening results & mail them to me at the above address.
- I also understand that this **testing should NOT be used as the only means to diagnose the existence or absence of any medical condition.** I understand that the Lab test results may be normal in the presence of certain disease states. I understand that I'm responsible for obtaining medical info or services from a qualified healthcare provider.
- I understand that it is **my responsibility to send/share this information with my provider**. GH Lab is not proposing diagnosis or recommending medical treatment, but is acting as a resource to provide this medical information. Should I become ill, have any complaints/questions about my health; it is my responsibility to contact my provider.
- I understand that these test results **will be included in the complete medical record** chart kept at GH.
- I am releasing all involved in this health screening from any & all liability for the results of the testing/screening or any treatment I may receive from a physician of my choice based upon the information provided by this program.
- **PSA screening may be recommended for men age 55-69**. Many exceptions may apply based upon your unique medical/ family history & other risk factors. For questions about this test or to ensure it's right for you, please contact your provider.
- I understand that because the tests are not ordered by a physician, **Medicare & insurance companies routinely do not cover the tests**. I understand that GH will NOT submit these tests for insurance reimbursement.
- *It's important to note that Medicare & other payers might cover identical tests if they were medically necessary & ordered by a physician, making it advisable to check with Medicare/your payer prior to choosing DAT.*

**I have read, understand, & agree to the above provisions:**

Participant's Signature_______________________________________________Date___________________

*(Legal Guardian signature if Participant is under 18 years of age.)*

**Please notify my GH provider that these tests have been done (mark beside the provider name if desired.)**

__Michelle Chew, DNP __Kayla Knauss, DO __Natalie Waskowiak, PA-C
__Mike Crisman, PA-C __Aaron Salomon, PA-C __Amanda Standage, APRN
__Anna Dalrymple, MD __Garret Shaw, MD

___$16.00 **Lipid Panel** ___$25.00 **PSA Screen** ___$40.00 **COVID-19** (Rapid)***
___$18.00 **Hemoglobin A1C** ___$16.00 **TSH** (Thyroid) ___$15.00 **CBC***
___$58.00 **Vitamin D** ___$19.00 **CMP*** ___$15.00 **Urine Drug Screen**

*Complete Blood Count (CBC), Comprehensive Metabolic Panel (CMP)*
***Note there is no blood draw fee associated with any testing. ***Supplemental form required.*

$___________Total Due Paid: Cash____Check #____Credit Card____Rec'd by_________

**Checks Payable to Gothenburg Health Tax ID# 47-0532605

| **FOR LAB USE ONLY** | Collection Date / / | Collection Time : | Lab Tech Initials: |
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*Gothenburg Health is an equal opportunity provider & employer.*