JOHNSON MEMORIAL HEALTH

*******Direct Access Testing Open M-F, 8am-4pm********

DIRECT ACCESS TEST CHARGE FORM

Patient:_____**Date:**_____

☐	**ABO/Rh**	**$30**
☐	**Basic Metabolic Profile**	**$30**
	Includes: Sodium, Potassium, Chloride, CO2, BUN, Creatinine, Glucose, Calcium	
☐	**Blood Count (CBC)**	**$25**
	Includes: WBC count, RBC count, Platelet count	
☐	**Renal Panel**	**$35**
	Includes: Sodium, Potassium, Chloride, CO2, BUN, Creatinine, Glucose, Calcium, Phosphorus, Albumin	
☐	**Cholesterol**	**$15**
☐	**Complete Metabolic Profile**	**$30**
	Includes: Sodium, Potassium, Chloride, CO2, BUN, Creatinine, Glucose, Calcium, AST, ALT, ALP, Tbil, Albumin, Total Protein	
☐	**Glucose**	**$15**
☐	**Pregnancy (blood or urine)**	**$30**
☐	**Hemoglobin A1C**	**$35**
☐	**Hepatic (Liver) Panel**	**$30**
☐	**Influenza Screen**	**$70**
☐	**Lipid Profile**	**$35**
☐	**Mono Screen**	**$30**
☐	**PSA**	**$50**
☐	**Strep Screen**	**$50**
☐	**Testosterone**	**$30**
☐	**Triglycerides**	**$15**
☐	**TSH**	**$45**
☐	**T4 Free**	**$45**
☐	**FSH**	**$40**
☐	**LH**	**$40**
☐	**Urinalysis**	**$20**
☐	**Urine Drug Screen**	**$30**
☐	**Vitamin B12**	**$30**
☐	**Folate**	**$35**
☐	**Vitamin D 25Hydroxy**	**$30**
☐	**Covid-19 Antibody**	**$25** (Do not charge venipuncture fee)
☐	**Covid-19 Antigen Swab**	**$50** (Do not charge venipuncture fee)

☐ **Women's Health Profile** **$155**
Includes Basic Metabolic Profile, Lipid Profile, TSH, Blood Count & urinalysis

☐ **Men's Health Profile** **$160**
Includes Basic Metabolic Profile, Lipid Profile, Blood Count, PSA, & urinalysis

☐ **Venipuncture** **$5**
*****Added to all blood samples***

Total Charges:_____

Please present this form to the cashier for payment prior to service.

You must obtain a receipt of payment and present to the Laboratory at the time of service.

I understand that the Hospital will not bill any type of insurance for these tests. I agree that I am responsible for full payment of services before they are rendered. I understand that a venipuncture charge will be added for any blood samples collected.

I agree that the test results may be sent to the address below by ordinary mail. I understand that my test results will not be released via the phone or fax, except as provided below.

I understand that Johnson Memorial Hospital will not interpret the test results for me. If I would like to have the results interpreted, I understand that I must discuss the results with my regular health care provider. You should anticipate a charge from your healthcare provider for this. I understand that a normal result does not guarantee that I do not need medical attention; likewise, an abnormal result may not necessarily be abnormal for me – my complete medical history must be considered.

I understand that Johnson Memorial Hospital may contact me directly by telephone with my test results if it appears that these results (*) are of a critical nature – at which time I would be responsible for contacting my physician with the results.

I release the Hospital and any persons involved with the taking of the sample from any liability arising: 1) from the taking of the sample and any ill effects that result from the test; 2) from disclosing results in the manner provided by law and/or allowed by me.

_____ _____
Patient's Printed Name Date of Birth

_____ _____
Patient's Signature Date

_____ _____
Signature of Parent or Legal Guardian Witness

Mailing Address:

_____
Street

_____, _____ _____
City State Zip

(_____)_____
Phone