JOHNSON MEMORIAL HEALTH
1125 West Jefferson Street
Franklin, IN 46131

DIRECT ACCESS TEST CHARGE FORM

Patient:____

Date:____________________________

Test	Charge
ABO/Rh	$30
Basic Metabolic Profile	$30
Blood Count (CBC)	$25
Cholesterol	$15
Complete Metabolic Profile	$30
Glucose	$15
Pregnancy (blood or urine)	$30
Hemoglobin A1C	$35
Hepatic Panel	$30
Influenza Screen	$70
Lipid Profile	$35
Mono Screen	$30
PSA	$50
Strep Screen	$50
Testosterone	$30
Triglycerides	$15
TSH	$45
Urinalysis	$20
Urine Drug Screen	$30
Vitamin B12	$30
Vitamin D 25Hydroxy	$30

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