



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