SULLIVAN COUNTY
LABORATORY SERVICES

DIRECT-ACCESS TESTING
Testing on your Terms
Order, Consent, Disclaimer of Liability Form

Last Name:_____First Name:_____ Birthdate_____

Address:_____Phone:_____ Sex: M F

Place a check mark beside the screening tests you would like to have performed.

✖	Test Name	Cost
	CBC	$25
	Glucose	$20
	HA1C	$35
	Lipid Panel-Fasting Required	$30
	PSA-Males Only	$35
	Thyroid (TSH/FT4)	$35
	Testosterone-Males Only	$45
	Urine Dipstick	$20
	Urine Drug Screen	$65
	Vitamin D (Total)	$45
	Basic Metabolic Profile-	$30
	Men's Health Panel (BMP. CBC, Lipids, PSA)- Fasting Required	$99
	Women's Health Panel (BMP, CBC, Lipids, TSH/FT4)- Fasting Required	$99
	Total Tests Ordered Total Amount Due	

Please carefully read the statements below.

1. If a value is critical, the hospital will call; however, SCCH employees will not interpret the test results for me. I must make an appointment with my healthcare provider.
2. A copy of test results will be mailed to the address I have provided on this form. I accept all responsibility if someone at that address, other than myself, should see the test results.
3. I should contact my physician before I start, change, or stop any medications or treatment plans.
4. **I am aware that the test results I will receive are for screening purposes and not a substitute for evaluation, advice, treatment, or diagnosis by a healthcare provider. The results received are for informational purposes only.**
5. "Normal" results fall within the normal reference ranges established in the tests and do not ensure wellness.
6. "Abnormal" means results fall outside normal reference ranges and may not indicate sickness or disease.
7. I understand I am to pay SCCH in full at time of service. There are no refunds, and I will receive no further billing.
8. The hospital will not submit these tests for payment to my insurance or Medicare.
9. These tests will not be included in my electronic medical record.
10. I must provide a working telephone number so that any critical values can be reported to me by phone.

I have read and understand the information provided to me in this disclaimer and I hereby authorize Sullivan County Community Hospital to complete the screening laboratory tests I have requested.

Signature_____ Date_____

Witness_____ Date_____