Gritman MEDICAL CENTER

Gritman Medical Center
700 S. Main St.
Moscow, ID 83843
208-882-4511

COMMUNITY WELLNESS CONSENT FOR TESTING

LAST NAME:	FIRST NAME:	DATE OF BIRTH: (MUST BE 18 YEARS OLD)
MAILING ADDRESS:		
CITY:	STATE:	ZIP:
PHONE:	GENDER: M F	**TOTAL DUE: $**13

I request Gritman Medical Center Laboratory staff perform the following tests:

☑	$13	**Blood Draw:** All visits that require a blood draw will have a blood draw fee added.	
☐	$20	**Pregnancy Test**: Qualitative screen for women. Detects presence or absence of hCG in blood or urine. Urine: first morning urine specimen preferred, not required.	B: LAB144 U: LAB9999
☐	$30	**Lipid Panel:** Useful for monitoring cholesterol, screening for lipid disorders, risks for heart disease; includes total cholesterol, HDL (high density lipoprotein), direct measure of LDL (low density lipoprotein), direct measure of triglyceride.	LAB18
☐	$25	**Hemogram**: Also known as a complete blood cell count (CBC). Includes total white cell count (no differential), red cell count, platelet count, hemoglobin, and hematocrit. Useful for routine health screens and identifying anemia, infection, and various blood diseases.	LAB294
☐	$35	**Hemoglobin A1C w/EAG:** A1C with estimated average glucose. Useful diabetes screening and monitoring tool. Monitors how well blood sugar levels are controlled in people with diabetes. Includes estimated average glucose calculation.	LAB90
☐	$35	**TSH:** Thyroid-stimulating hormone; screening of thyroid function.	LAB129
☐	$35	**PSA:** Prostate-specific antigen; blood test for prostate cancer screening in men.	LAB8624
☐	$30	**Blood Typing:** ABO/Rh; blood test to determine blood type.	LAB895
☐	$45	**Vitamin D:** Quantitative test to identify vitamin D total; used primarily to monitor vitamin D deficiency.	LAB535

How would you like to receive your lab test results? **MAIL** **PICK UP** **MYCHART**

How did you hear about the "Results for a Healthier Community Program"?
Word of Mouth **Website** **Newspaper** **Other: _____**

I hereby authorize Gritman Medical Center to perform the laboratory tests I have requested.

Signature:_____Date:_____

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COMMUNITY AND SURROUNDING AREAS FORM DISCLAIMER

Having requested the laboratory screening tests above, I understand that:

- Laboratory results from the Healthier Community Program are for informational purposes only and are not a substitute for medical advice, diagnosis, or treatment.
- I am aware that I should consult my physician before I stop, start, or change any treatment plan, including use of medication.
- I am responsible for consulting a physician.
- Neither Gritman Medical Center, nor its employees, will interpret the results for me.
- I understand that results which fall in the "Normal" range may not ensure health.
- I understand that results may fall out of the "Normal" range and may not indicate disease.
- I understand that lab tests are not a substitute for a full medical evaluation by a physician.

Please initial each statement:

_____ I will not hold liable Gritman Medical Center, its officers, directors, employees, affiliates, and sponsors for any outcomes, which may result from my participation in this testing option.

_____ If I have requested that my results be mailed to me at the address listed on the consent form, I retain all responsibility should someone else at the address view the results.

_____ I have provided a phone number at which I can be reached in the event that critical lab values are obtained.

_____ I understand that my results will not be sent to a physician and that I am responsible to take my results to my personal health care provider.

_____ I understand that I am expected to pay Gritman Medical Center in full at the time of service, that no insurance billing or patient statement billing will occur, and that there is no refund option available. If I am eligible for Medicare benefits, I am aware that Medicare does not cover this service and I am fully responsible for payment at this time.

_____ I HEREBY on behalf of myself and all of my representatives, legal representatives, creditors, heirs, and assigns, release, acquit and forever discharge Gritman Medical Center, its agents, employees and all other persons whomsoever directly or indirectly liable, from any and all claims, causes of action, damages or claims of damage whatsoever, including negligence. Both in law and equity, or in any way resulting from personal injury or death, or other damages sustained by me, as a result of my self-referral for the test(s) I have requested to be performed by Gritman Medical Center.

I have read and understand the information provided to me in this disclaimer.

Signature:_____ DATED this_____day of_____, 20_____

My results should be mailed to:

Name: _____

Mailing Address: _____

City:_____ State:_____ Zip:_____