



The choice that makes a difference. Proudly owned by physicians

Consent Form

Please complete this form prior to your appointment and bring it with you.

Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Home #: \_\_\_\_\_ Work #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Email address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_

Requested laboratory tests:

Table with 3 columns: Test, Cost, Code. Lists various lab tests such as Blood type, Calcium, CEA, etc.

Table with 3 columns: Test, Cost, Code. Lists various lab tests such as Magnesium, MMR Immunity Panel, Mononucleosis, etc.

Total Amount Due: \$ \_\_\_\_\_

I would like my results sent via: [ ] Mail [ ] Email [ ] Fax #: \_\_\_\_\_ [ ] I will pick up

Primary Care Physician (optional): \_\_\_\_\_ Send results to him/her: [ ] Yes [ ] No

If you do not have a primary care physician would you like us to refer you to one? [ ] Yes [ ] No

Must be at least 18 years old or be accompanied by a parent or guardian.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Authorized Representative Signature: \_\_\_\_\_ Relationship: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_