Orange City Area Health System

Acknowledgement of Interpretation of Laboratory Test Results and Receipt of Notice of Privacy Practices

Collection **ONLY**:

- ☐ Draw/Kit Process ($40)
- ☐ Venipuncture ($15)

Testing **(don't need to include collection)**:

- ☐ ABO/Rh Blood Typing 86900/86901 ($20)
- ☐ Anti-TPO 86376 ($30)
- ☐ Amylase 82150 $20
- ☐ CA125 86304 $50
- ☐ CEA 82378 $50
- ☐ Complete Blood Count 85025 ($15)
- ☐ Comprehensive Metabolic Panel 80053 ($25)
- ☐ Cortisol 82533 $30
- ☐ CPK 82550 ($10)
- ☐ CRP 86140 ($15)
- ☐ DHEA-S 82627 $30
- ☐ ESR 85652 ($10)
- ☐ Estradiol 82670 ($30)
- ☐ Fasting Blood Sugar 82947 ($10)
- ☐ Ferritin 82728 ($20)
- ☐ Folate 82746 ($30)
- ☐ Free T3 84481 ($30)
- ☐ Free T4 84439 ($15)
- ☐ FSH 83001 $30
- ☐ HCG Quant 84702 ($30)
- ☐ HCG Screen 84703 ($20)
- ☐ Hemoglobin A1C 83036 ($20)
- ☐ Hep C 86803 $40
- ☐ HIV 87389 $40
- ☐ HBSAG 83525 $40
- ☐ Insulin 83525 ($30)
- ☐ Iron 83540 ($10)
- ☐ Iron Binding 83550 ($15)
- ☐ LH 83002 $30
- ☐ Lipase 83690 ($20)
- ☐ Lipid Panel 80061 ($25)
- ☐ Magnesium 83735 ($10)
- ☐ Intact PTH 83970 ($40)
- ☐ Prolactic 84146 ($30)
- ☐ Progesterone 84144 ($30)
- ☐ Prostate Specific Antigen 84153 ($30)
- ☐ Rheumatoid Factor 86431 $25
- ☐ Sex Hormone Binding Globulin (SHBG) 84270 $30
- ☐ Syphilis 86780 $40
- ☐ Testosterone, Total 84403 ($30)
- ☐ Thyroid-Stimulating Hormone 84443 ($25)
- ☐ Uric Acid 84550 ($10)
- ☐ UA Dipstick Micro 81001 ($10)
- ☐ Vitamin B12 82607 ($30)
- ☐ Vitamin D 82306 ($25)

I hereby request the laboratory tests/screens selected above be performed for me. I understand the responsibility for initiating a follow-up examination to interpret or confirm any of the results and obtain advice and treatment is mine and not that of my physician or Orange City Area Health System. I understand that payment for testing is due prior to the testing and that Orange City Area Health System Direct Access will not submit any claims for this encounter to my insurance, Medicare, Medicaid, or any other third-party payor. I also understand results will be available in MySanford Chart but will not be reviewed by a physician unless I initiate it.

I understand the data derived from this test is not conclusive. Testing may vary depending upon age, sex, time of day sample is taken, diet, medications, and the limits of modern technology. When evaluating my health, my complete medical history must be considered – laboratory testing is only one part of the evaluation. Furthermore, laboratory tests identify certain discrete health indicators only and are in no way a substitute for a regular and thorough physical performed by my personal physician. I realize a normal result does not guarantee I do not need medical attention; likewise, an abnormal result may not necessarily be abnormal for me – my complete medical history must be considered by a physician. Also, false positive and false negative results are possible.

If I am not feeling well, I understand that Orange City Area Health System recommends that I see a physician immediately. I hereby release Orange City Area Health System, its parent and affiliated companies, and their officers, directors, and employees, from any and all liability arising from or in any way connected to my failure to follow up with a physician regarding interpretation of the test results or for treatment of advice. I hereby acknowledge I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed and outlines my rights with respect to such information. I understand I should read it carefully. I am aware the Notice may change at any time. I may obtain a revised copy of the Notice by visiting https://ochealthsystem.org/privacy/.

Patient printed name: _____ DOB:_____

Patient
Signature_____Date_____

- As the representative of the above individual, I acknowledge receipt of the Acknowledgment & Notice of his/her behalf.
- Signature_____Date_____

Notice of Privacy Practices: ☐ Declined Copy ☐ Received Copy

Acknowledgement of Interpretation of Laboratory Test Results and Receipt of Notice of Privacy Practices: ☐ Declined Copy ☐ Received Copy

Staff
Signature_____Date_____

Total Amount Paid $_____