OSCEOLA COMMUNITY HOSPITAL

DIRECT LABS 712-754-5304

DATE:_____

TIME:_____

Name _____ ☐ Male ☐ Female

Phone number _____ ☐ Fasting ☐ Non-Fasting

Date of birth _____

Address _____

Complete Blood Count (HS.CBC).....$15	Lipid Panel (HS.LIPID).....$25
Comprehensive Metabolic Panel (HS.CMP).....$25	TSH (HS.TSH).....$30
General Wellness Screen (HS.QL).....$50	Vitamin D 25, Hydroxy (HS.VITD).....$50
Glucose (HS.GLU).....$10	Thyroid Panel (HS.THY).....$45
Hemoglobin A1C (HS.HGBA1C).....$25	PSA (HS.PSA).....$35

☐ Credit Card ☐ Cash ☐ Check Total Amount Due: _____

Consent to Laboratory Testing

I authorize Osceola Community Hospital to perform the laboratory tests as requested by me. I understand that Osceola Community Hospital is not obligated to report results to my physician or insurance company.

I understand the laboratory testing I requested is not a substitute for a full examination by my own physician/provider. I accept responsibility for arranging any follow-up examinations indicated necessary by the report I receive.

I understand that the results of my laboratory testing will be maintained in the electronic health record system at Osceola Community Hospital. Osceola Community Hospital agrees to treat the medical information in my record as confidential as required by the Health Insurance Portability and Accountability Act (HIPAA).

HIPAA Acknowledgment

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. As stated in our notice, the terms of the notice may change. If we change our notice, you may obtain a revised copy by contacting the Privacy Office at Osceola Community Hospital. By signing this form, you acknowledge that you have received a copy of our Notice of Privacy Practices dated March 1, 2017.

Wireless Communications

I hereby agree that by providing my wireless/cell phone number, I am, granting my consent to receive automatic dialing calls on my wireless/cell phone number for any billing, accounting, collection or other financial contact. Methods of contact may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

☐ Decline

_____	_____ _____
Witness Signature	Patient, Parent or Legal Representative Signature / Relationship to Patient *If patient under 18 years of age*
Date _____ Time _____ AM / PM	Date _____ Time _____ AM / PM