RMH LAB DISCOUNT FOR CASH

*****Need Practitioner Order***** *****Must Register Patient*****

******Discount Pricing Must Be Paid at Time of Service******

Roundup Memorial Healthcare
PO Box 40 - 1202 3rd St. West
Roundup , MT 59072

Telephone: 406-323- 2301
Lab Fax : 406-323-1170

Last Name: ____________________________ MI: _____ First Name: ____________________________ Date: _______________

Address: ____ City: _________________________ State: _______ Zip: ______________

Telephone #: __________________________________ Gender: Male Female

Date of Birth: _____/_____/_____ ****Note: Must be 18 years of age or legally emancipated to request tests.*

I request the following laboratory tests and authorize Roundup Memorial Healthcare to complete these tests:

☐	Basic Metabolic Panel - $15.00	☐	***HIV 1 & 2 Screen - $30.00**	☐	Urinalysis - $18.00
☐	Blood Type - $17.00	☐	Hematocrit - $10.00	☐	***Urine Culture - $38.50**
☐	CBC - $18.00	☐	Hemoglobin A1C - $24.00	☐	***to include Organism ID if needed***
☐	CBC+Diff - $21.00	☐	Hepatic Function Panel - $20.00	☐	***Urine Culture - $50.00**
☐	CA-125 - $47.50	☐	High Sensitivity C-Reactive Protein (HS-CRP) - $30.00	☐	***to include ID if needed w/ reflex to MIC***
☐	Calcium - $10.00	☐	Homocysteine - $40.00	☐	Urine Microalbumin - $15.00
☐	Cholesterol - $10.00	☐	Iron - $18.00	☐	Vitamin B12 - $35.00
☐	Cholesterol Panel - $30.00	☐	Iron Panel - $65.00	☐	Vitamin B12 + Folate - $55.00
☐	Clos Diff - $60.00	☐	Lipase - $15.00	☐	Vitamin D - $55.00
☐	Comp. Metabolic Panel - $25.00	☐	Magnesium - $15.00	☐	5-Part Urine Tox Screen - $50.00
☐	Creatinine (Urine or Blood) - $15.00	☐	Mono Test - $17.00	☐	Sed Rate - $15.00
☐	C-Reactive Protein (CRP) - $15.00	☐	PSA - $37.00	☐	Spice Screen - $25.00
☐	FT3 - $38.00	☐	Phosphorous - $13.00	☐	Other: ______________________
☐	FT4 - $35.00	☐	Pregnancy Test (Blood or Urine) - $20.00	☐	
☐	Ferritin - $35.00	☐	***Protime-INR - $30.00**	☐	
☐	Folate - $30.00	☐	TSH - $25.00	☐	
☐	Glucose - $10.00	☐	Testosterone, Total - $50.00	☐	
☐	Glucose Tol. Test (2 Hr) - $20.00	☐	Uric Acid - $15.00	☐	

DRAWING FEE: $17.00 (PLEASE APPLY A DRAWING FEE FOR ALL "DISCOUNT FOR CASH"!!!)

TOTAL AMOUNT DUE: $ __________ Payment Method: __CASH __CHECK __CREDIT CARD

By requesting the above laboratory tests, I understand that:

* Laboratory results from RMH are **NOT** a substitute for medical advise, diagnosis, or treatment.
* I should consult a physician before I stop, start or change any treatment plan, inluding the use of medication, RMH is not responsible for initiating a visit with a physician.
* I understand that results within the normal range do not indicate absence of disease.
* I understand that results that fall outside the normal range do not indicate presence of disease.

Please initial each statement:

___ I understand that positive results to HIV will warrant mandatory counselling.

___ Laboratory results will be forwarded to requesting practitioner.

___ I shall pay RMH in full at the time of service. With these reduced lab test fees, it shall be understood, no other billing will occur to any third party. I am aware RMH will not submit any claims to my private insurance company. No refund is available if I am eligible to receive Medicare and/or Medicaid benefits. I am aware that Medicare and Medicaid do not cover this service and I am fully responsible for the payment at this time.

___ Notice of Privacy Practices (NOPP); My initials acknowledge receipt of the RMH NOPP.

SIGNATURE: ______________________________________ ***DATE:*** ______________________

RMH LAB DIRECT TESTING

*****No Physician Order Needed***** *****No Need to Register*****

******Discount Pricing Must Be Paid at Time of Service******

Roundup Memorial Healthcare
PO Box 40 - 1202 3rd St. West
Roundup , MT 59072

Telephone: 406-323- 2301
Lab Fax : 406-323-1170

Last Name: ____________________ MI: _____ First Name: ____________________ Date: ____________

Address: ______________________________ City: ____________________ State: _______ Zip: ____________

Telephone #: ____________________________ Gender: Male Female

Date of Birth: _____/_____/_____ ****Note: Must be 18 years of age or legally emancipated to request tests.*

I request the following laboratory tests and authorize Roundup Memorial Healthcare to complete these tests:

☐	Basic Metabolic Panel - $15.00	☐	Glucose - $10.00	☐	Testosterone, Total - $50.00
☐	Blood Type - $17.00	☐	Glucose Tolerance Test (2 Hr) - $20.00	☐	Uric Acid - $15.00
☐	CBC - $18.00	☐	Hematocrit - $10.00	☐	Urinalysis - $18.00
☐	CBC+Diff - $21.00	☐	Hemoglobin A1C - $24.00	☐	Urine Microalbumin - $15.00
☐	CA-125 - $47.50	☐	Hepatic Function Panel - $20.00	☐	Vitamin B12 - $35.00
☐	Calcium - $10.00	☐	High Sensitivity C-Reactive Protein (HS-CRP) - $30.00	☐	Vitamin B12 + Folate - $55.00
☐	Cholesterol - $10.00	☐	Homocysteine - $40.00	☐	Vitamin D - $55.00
☐	Cholesterol Panel - $30.00	☐	Iron - $18.00	☐	5-Part Urine Tox Screen - $50.00
☐	Comp. Metabolic Panel - $25.00	☐	Iron Panel - $65.00	☐	Sed Rate - $15.00
☐	Creatinine (Urine or Blood) - $15.00	☐	Magnesium - $15.00	☐	Spice Screen - $25.00
☐	C-Reactive Protein (CRP) - $15.00	☐	Mono Test - $17.00	☐	Other: ____________________
☐	FT3 - $38.00	☐	PSA - $37.00	☐	
☐	FT4 - $35.00	☐	Phosphorous - $13.00	☐	
☐	Ferritin - $35.00	☐	Pregnancy Test (Blood or Urine) - $20.00	☐	
☐	Folate - $30.00	☐	TSH - $25.00	☐	

*****ALL DRAWING FEES INCLUDED WITH THE PRICE*****

TOTAL AMOUNT DUE: $ __________ Payment Method: __CASH __CHECK __CREDIT CARD

By requesting the above laboratory tests, I understand that:

* Laboratory results from RMH are **NOT** a substitute for medical advise, diagnosis, or treatment.

* I should consult a physician before I stop, start or change any treatment plan, inluding the use of medication, RMH is not responsible for initiating a visit with a physician.

* I understand that results within the normal range do not indicate absence of disease.

* I understand that results that fall outside the normal range do not indicate presence of disease.

Please initial each statement:

___ Laboratory results will be mailed to patient.

___ I shall pay RMH in full at the time of service. With these reduced lab test fees, it shall be understood, no other billing will occur to any third party. I am aware RMH will not submit any claims to my private insurance company. No refund is available if I am eligible to receive Medicare and/or Medicaid benefits. I am aware that Medicare and Medicaid do not cover this service and I am fully responsible for the payment at this time.

___ Notice of Privacy Practices (NOPP); My initials acknowledge receipt of the RMH NOPP.

SIGNATURE: ______________________________ ***DATE:*** ____________________