

# 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:**

<input type="checkbox"/> Basic Metabolic Panel - \$15.00	<input type="checkbox"/> Glucose - \$10.00	<input type="checkbox"/> Testosterone, Total - \$50.00
<input type="checkbox"/> Blood Type - \$17.00	<input type="checkbox"/> Hematocrit - \$10.00	<input type="checkbox"/> Uric Acid - \$15.00
<input type="checkbox"/> CBC - \$18.00	<input type="checkbox"/> Hemoglobin A1C - \$24.00	<input type="checkbox"/> Urinalysis - \$18.00
<input type="checkbox"/> CBC+Diff - \$21.00	<input type="checkbox"/> Hepatic Function Panel - \$20.00	<input type="checkbox"/> Urine Microalbumin - \$15.00
<input type="checkbox"/> CA-125 - \$47.50	<input type="checkbox"/> Homocysteine - \$40.00	<input type="checkbox"/> Urine Micro/Creat Ratio - \$15.00
<input type="checkbox"/> Calcium - \$10.00	<input type="checkbox"/> Iron - \$18.00	<input type="checkbox"/> 5-Part Urine Tox Screen - \$50.00
<input type="checkbox"/> Cholesterol - \$10.00	<input type="checkbox"/> Iron Panel - \$65.00	<input type="checkbox"/> Vitamin D - \$55.00
<input type="checkbox"/> Cholesterol Panel - \$30.00	<input type="checkbox"/> Magnesium - \$15.00	<input type="checkbox"/> Vitamin B12 - \$35.00
<input type="checkbox"/> Comp. Metabolic Panel - \$25.00	<input type="checkbox"/> Mono Test - \$17.00	<input type="checkbox"/> Vitamin B12 + Folate - \$55.00
<input type="checkbox"/> Creatinine (Urine or Blood) - \$15.00	<input type="checkbox"/> PSA - \$37.00	<input type="checkbox"/> Other: _____
<input type="checkbox"/> C-Reactive Protein (CRP) - \$15.00	<input type="checkbox"/> Phosphorous - \$13.00	<input type="checkbox"/>
<input type="checkbox"/> FT3 - \$38.00	<input type="checkbox"/> Pregnancy Test (Blood or Urine) - \$20.00	<input type="checkbox"/>
<input type="checkbox"/> FT4 - \$35.00	<input type="checkbox"/> Sed Rate - \$15.00	<input type="checkbox"/>
<input type="checkbox"/> Ferritin - \$35.00	<input type="checkbox"/> Spice Screen - \$25.00	<input type="checkbox"/>
<input type="checkbox"/> Folate - \$30.00	<input type="checkbox"/> TSH - \$25.00	<input type="checkbox"/>

**\*\*\*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, including 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:** \_\_\_\_\_