

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:

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

DRAWING FEE: \$22.00 (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, 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:

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: _____