# WEST PARK *HEALTHCHECK* PATIENT FORM

(Order, Consent and Disclaimer of Liability)

**Please complete this form and bring it with you**

First Name: _____ Last Name: _____ DOB: ___/___/___ M F (Circle One)

Address: _____ Phone: (___) _____

Street or PO Box City State Zip

I wish to have the following screening tests performed: **TOTAL AMOUNT DUE: $ _____**

- ☐ Health Panel for Women $65.
- ☐ Health Panel for Men $80.
- ☐ Chemistry Panel (Health Fair) $40.
- ☐ Chem Panel / CBC $45.
- ☐ Vitamin D $45.
- ☐ Glycohemoglobin (A1C) $35.
- ☐ Lipid / Cholesterol Panel $25.
- ☐ CBC (Complete Blood Count) $20.
- ☐ Pregnancy Test (Blood) $20.
- ☐ Microalbumin / A1C Combo $55.
- ☐ PSA $40.
- ☐ Cholesterol $10.
- ☐ Blood Sugar (Glucose) $10.
- ☐ Blood Type $40.
- ☐ Microalbumin $30.

**West Park *HealthCheck* employees will not interpret the above test results for me.**

* I understand I will receive one copy of my test results, mailed to the address I have provided on this form. Additional copies may be obtained, for a small fee, at West Park Hospital's Health Information Management Dept.
* I am responsible for consulting a physician regarding the above test results. No one but myself will be sent any copies of these test results. I am responsible for sharing these test results with my doctor. For any questions or interpretations of test results, I will contact my primary physician.
* I am aware that I should contact a physician should I desire to start, change or stop **any** medications or treatment plans.
* I am aware that the above test results are for screening purposes and are not a substitute for evaluation, advice, treatment, or diagnosis by a physician; the results I receive are for my informational purposes only.
* I understand results I receive that are reported as "normal" (that is, they fall within the normal ranges established for the above tests) do not insure wellness.
* I understand results I receive that are reported as "abnormal" (that is, they fall out of the normal range established for the above tests) may not indicate sickness or disease.

**By initialing below, I am acknowledging that I understand and agree to the following statements:**

____ I understand that I am to pay West Park *HealthCheck* for the above tests in full at the time of service. There is no refund option, and I will receive no further billing. I understand the above tests are not covered by Medicare and probably not by private insurance.

____ I understand my results will be mailed to me at the address I have provided. I accept all responsibility should someone at that address other than myself access my test results. I understand I must provide a telephone number I can be reached at, in the event any of my results fall into the critical range.

____ I will not hold West Park Hospital District, its' employees, or agents liable for any outcomes that may occur from my voluntary participation in this laboratory testing. I am assuming all responsibility and risk of having tests ordered without active participation from a physician.

I have read and understand the above information provided to me in this disclaimer and I hereby authorize West Park *HealthCheck* to complete the screening laboratory tests I have requested.

Signature: _____ Date: _____

Witness: _____ Date: _____



*6020-00010*

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