

<b>P A T I E N T</b>	<b>PLEASE PRINT FULL LEGAL NAME</b>		
	LAST	FIRST	MI
	MAILING ADDRESS		
	CITY	STATE	ZIP CODE
	SEX	AGE	BIRTHDATE
	SS# (last four numbers)		TELEPHONE NUMBER

<b>LAB USE ONLY</b>	
<b>Unit #</b>	_____
<b>Acct. #</b>	_____
<b>Date</b>	_____
<b>Time</b>	_____
<b>Phleb</b>	_____

<b>HEALTHCHECK LAB TESTS</b>					
	CMP + Lipid	\$55.00		Homocysteine	\$45.00
<b>Individual Tests</b>				Iron	\$15.00
	Apolipoprotein B	\$48.00		Lipid Panel	\$30.00
	CBC	\$30.00		Lipoprotein A	\$48.00
	CMP	\$35.00		PSA	\$40.00
	C Reactive Protein	\$50.00		Sed Rate	\$30.00
	Free T-4 (FT4)	\$36.00		TSH	\$30.00
	Glyco A1c	\$35.00		Urinalysis	\$20.00
	HIV 1 & 2	\$40.00		Vit D Hydroxy	\$55.00

<b>HEALTHCHECK STAFF ONLY</b>		
Blood Thinners	Yes	No
Fasting	Yes	No
Blood Pressure		

**HEALTHCHECK PROGRAM CONSENT**

The undersigned hereby requests that health screening examinations/tests be performed under the sponsorship of Carson Tahoe Regional Healthcare (CTRH). I understand that there may be nominal fees for some of the examinations/tests performed.

I hereby release Carson Tahoe Regional Healthcare from any and all liability, including any matter or thing committed or omitted which may arise during blood drawing or other examinations/tests or from data derived therefrom.

It is understood that:

1. The data derived from such examinations/tests is considered as preliminary.
2. The responsibility for initiating any follow-up examination for abnormalities identified at the HealthCheck Appointment lies with me as the person responsible for my own health.
3. The Physician of Record will have access to my test results for the sole purpose of ascertaining if the results are abnormal and, if requested, aiding me in initiating a follow-up exam.
4. No other individual or agency will have access to my individual test results without express written permission from me.

Our notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms may change. If we change our notice, you may obtain a revised copy via our website at [www.carson Tahoe Regional Healthcare](http://www.carson Tahoe Regional Healthcare) or by contacting the Patient Registration Department at Carson Tahoe Regional Healthcare. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. Your signature also authorizes CTRH to provide a copy of the results from this HealthCheck visit to you at the address listed above. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consents. **This consent will remain in effect until we receive written notification from you.**

\_\_\_\_\_  
Signature of Patient/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
HealthCheck Staff Witness

\_\_\_\_\_  
Date

