Patient Consent for Molecular Genetic Testing

Patient Acknowledgement: I acknowledge that the information provided by me on the test requisition form (TRF) is true and correct. For direct insurance / 3rd party billing: I hereby authorize my insurance benefits to be paid directly to ^] v š }( ] } Œ šŒ and authorize them to release medical information concerning my testing to my insurer and that I am financially responsible for any amounts not covered by my insurer. I understand that I am legally responsible for sending ^] v š }( ] } Œ šŒ any money received from my health insurance company. I also authorize ^] v š }( ] } Œ šŒ my designated representative for purposes of appealing any denial of benefits as needed. I acknowledge that ^] v š }( ] } Œ šŒ has the right to request additional medical records, such as consult notes, pedigrees, and clinical / family history notes directly from my provider(s) for the purposes of insurance verification and billing. For patient payment by credit card: I hereby authorize ^] v š }( ] } Œ šŒ my credit card.

In order to expedite consideration for eligibility for ^ Financial Assistance Program, please provide the total annual gross household income: $_____ and the number of family members in the household supported by the listed income: _____. I authorize ^] v š] ( ] > } Œ šŒ to verify the above information for the sole purpose of assessing financial need, including the right to seek supporting documentation.

I have read or have had read to me all of the above statements and understand the information regarding molecular genetics testing and have had the opportunity to ask questions I might have about the testing, the procedure, the risks, and the alternatives prior to my informed consent. My signature below acknowledges my voluntary participation in this molecular genetic testing and such genetic analysis in no way guarantees my health, the health of an unborn child, or the health of other family members.

_____ _____

Patient (or authorized individual) Signature Date

_____ _____

Patient Name (please print) Authorized Individual Name and Relationship (please print)