MyLab Program Authorization & Disclaimer

MyLab Program (formerly LabCheck)

Holy Rosary Hospital

LAB USE ONLY
Specimen Collection: Date: _____ Time: _____ Initial: _____ Fasting: ☐ Yes ☐ No

Please complete this form prior to your appointment and bring it with you.

First Name: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Date of Birth: _____/_____/_____ Gender: ☐ Male ☐ Female

***MyLab* test results are available in MyChart.**

General Health

- ☐ Blood Type (500095) – $25
- ☐ C-Reactive Protein, Inflammation (500228) – $30
- ☐ (COMP) Chemistry Screen (500214) – $30
- ☐ (CBC) Complete Blood Count (500195) – $20
- ☐ Ferritin (500300) – $30
- ☐ Folate (500305) – $30
- ☐ Homocysteine (500370) – $35
- ☐ Iron Panel (500391) – $45
- ☐ Kit Fee (521233) – $40
- ☐ Lipid Panel with Reflex (500408) – $48
- ☐ Magnesium (500417) – $15
- ☐ Microalbumin/Creatinine Ratio, Urine (520403) – $25
- ☐ MMR Immunity (500431, 501269, 502293) – $95
- ☐ Occult Blood Immunoassay, Stool (516679) – $65
- ☐ Sed Rate (501192) – $10
- ☐ Uric Acid (500586) – $15
- ☐ Urinalysis (500920) – $15
- ☐ Vitamin B12 (500599) – $32
- ☐ Vitamin D 25 OH (500604) – $60

Diabetes Management

- ☐ Glucose (500322) – $15
- ☐ Hemoglobin A1c (500341) – $25

Thyroid Management

- ☐ TSH with Reflex to Free T4 (516734) – $49
- ☐ TSH without Reflex (580256) – $35
- ☐ T3, Free (500541) – $35

Men's Health

- ☐ Prostate-Specific Antigen (520077) – $40
- ☐ Testosterone, Total, Male (501690) – $55

Women's Health

- ☐ Estradiol (500276) – $40
- ☐ Follicle Stimulating Hormone (500309) – $36
- ☐ Luteinizing Hormone (500405) – $36
- ☐ Pregnancy Test, Serum (500333) – $25
- ☐ Progesterone (500487) – $45

Total Amount Due $ _____

Holy Rosary Hospital Laboratory is not responsible for mailing or faxing *MyLab* results to patient's care provider. Once results have been released to patient, it is the patient's responsibility to provide results to their care provider.

I hereby authorize Holy Rosary Hospital *MyLab* to complete the laboratory tests I have requested.

***Must be at least 18 years of age**

_____ _____ _____
Patient Signature Date Time

_____ _____ _____ _____
Witness Signature Printed Name Date Time

Intermountain Health

Holy Rosary Hospital

Patient Label

MyLab Program Disclaimer

Having requested these specific laboratory test(s) I understand that:

- Laboratory results from Holy Rosary Hospital *MyLab* are for informational purposes only and are not a substitute for medical advice, diagnosis or treatment.
- I am aware that I should consult a physician before I stop, start or change any treatment plan, including the use of medication.
- I am responsible for consulting a physician.
- Neither Holy Rosary Hospital *MyLab* nor its employees will interpret the results for me.
- I understand that results within the normal range do not ensure health.
- I understand that results that fall outside the normal range may not indicate disease.
- I understand that lab tests are not a substitute for a full medical evaluation.

Please initial each statement below:

_____ I am 18 years of age or older.

_____ I will not hold Holy Rosary Hospital *MyLab*, its Officers, Director, employees, affiliates and sponsors liable for any outcomes which may result from my participation in this testing option.

_____ I acknowledge that my results will be accessible via MyChart, and it is my responsibility to convey these results to my healthcare provider(s). I have also provided a phone number at which I can be reached in the event that critical lab values are reported.

_____ I understand that I am expected to pay Holy Rosary Hospital *MyLab* in full at the time of service, that no other billing will occur, and that there is no refund option available. If I am eligible to receive Medicare benefits, I am aware that Medicare does not cover this service and I am fully responsible for payment at this time.

I have read and understand the information provided to me in this disclaimer.

_____ _____ _____

Patient Signature Date Time

Holy Rosary Hospital

Patient Label