

CODY REGIONAL HEALTH 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 \$90. ☐ Health Panel for Men \$105. ☐ Chemistry Panel (Health Fair) \$50 ☐ Chem Panel / CBC \$65. ☐ Vitamin D \$45. 	☐ Lipid / Chole . ☐ CBC (Comp ☐ Pregnancy	globin (A1C) \$45. esterol Panel \$40. blete Blood Count) Test (Blood) \$35. in / A1C Combo \$9		☐ Testo	\$45. (Thyroid Stim Hormone) \$25. osterone \$50. d Type \$50. oalbumin \$50.
Cody Regional health 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 Cody Regional Health'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 physical treatment and results I receive that the above tests) do not insure well and the above tests I receive that for the above tests) may not indicate the above tests. 	cian; the results I rec are reported as "norr lness. are reported as "abn	eive are for my informal" (that is, they falormal" (that is, they	rmationa II within t	l purposes he norma	s only. I ranges established for
By initialing below, I am acknowledging that I understand and agree to the following statements:					
I understand that I am to pay Cody Regional Health 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 Cody Regional H voluntary participation in this la without active participation fron	boratory testing. I an				
I have read and understand the above information provided to me in this disclaimer and I hereby authorize Cody Regional Health <i>HealthCheck</i> to complete the screening laboratory tests I have requested.					
Signature:		Date:			
Witness:		Date:			



Page 1 of 1 Revised: 02/2023 6020-00010