GPLHC Consent Statement

Please mark the test(s) or panel(s) that you would like performed.
Payment *in full* is required *before* collection of samples.

❑ Community Wellness Panel *fasting	$45	Lipid Panel, CMP, TSH, Hemoglobin
❑ Lipid Panel & Glucose *fasting	$25	Cholesterol, Triglycerides, HDL, Calculated LDL, Glucose
❑ Limited Renal Panel	$15	Sodium, Potassium, and Creatinine
❑ CMP *fasting	$15	Electrolytes, Glucose, BUN, Creatinine, Calcium, AST, ALT, Alk Phos, Albumin, Total Bili, Total Protein
❑ TSH	$25	Thyroid

❑ Hematology Wellness	$20	White blood cell, red blood cell, hemoglobin, hematocrit, platelets
❑ Liver Panel	$15	AST, ALT, Alk Phos, Albumin, Total Protein, Total & Direct Bili
❑ Hemoglobin A1C	$15	Average blood sugar for the last 3 months
❑ Free T4	$25	Thyroid
❑ PSA	$30	Prostate Wellness
❑ Microalbumin	$15	
❑ Iron	$15	with Iron Binding Capacity
❑ Uric Acid	$10	Gout
❑ Ferritin	$25	Anemia/Iron Deficiency
❑ Vitamin D	$35	

I hereby release Gundersen Health System (GHS) from any and all liability arising from, or in any way connected to, drawing samples from my body for my wellness testing. I understand the data derived from this testing is considered preliminary only and is in no way conclusive. The responsibility for initiating a follow-up exam to confirm any abnormal tests, and obtain advice and treatment is mine, and mine alone, not that of GHS.

As a patient, I am choosing to pay cash for today's laboratory services. I agree to pay for these services in full before receiving them. I realize these services may be a covered benefit through my health insurance plan, but I am choosing to pay cash instead. I understand that by paying cash I likely will not be able to seek reimbursement from my health insurance for any of these services. I recognize that if I do attempt to seek reimbursement from my health insurance, I may be responsible for violating its benefit requirements. I agree that Gundersen shall not be held liable or responsible for my decisions. I also realize this cash payment may not count towards my health insurance deductible. This may result in higher out of pocket expenses than if I chose to use my health insurance for these services, but I prefer to pay cash instead.

Printed Name			Patient Label	
Date of Birth				
Signature				
Time	**Tech**	**Fasting** Y / N	**Amount Collected** $	**By**
			Payment Type Cash | Check | Credit / Debit	

Revised 09/2022