2018
CMMC Annual Community Lab Screening
Registration/Consent

Name: ____ Male____ Female ______

Address: ____City: ____________________Zip: ____________

Phone: ________________________Cell: ____________________Age: _______Date of Birth: _____________

Consent: I authorize representatives of CMMC to collect, by venipuncture, a blood specimen for the purpose of analysis of the following tests: **Please select the desired tests:**

Mark Appropriate Tests	Date of Service	Place Of Service	CPT Code	ICD-10	Charge	Tests
		11	80053	Z00.00	$17	Complete Metabolic Panel
		11	80061	Z00.00	$19	Lipid Panel
		11	85027	Z00.00	$16	Hemogram
		11	84153	Z00.00	$35	PSA(Men Only)
		11	84443	Z00.00	$33	Thyroid Test (TSH)
		11	82306	Z00.00	$47	Vitamin D Total, 25-OH
		11	83036	Z00.00	$30	Hemoglobin A1C
		11	86803/87522	Z00.00/Z72.89	$40	Hepatitis C w/reflex if positive

For chemistry screens, please fast for 8-12 hours. You may drink normal amounts of water.

Chemistry Screen: Includes glucose, general electrolyte, liver and kidney function
Lipid Panel: Includes cholesterol
Hemogram: Screens for anemia, infection & leukemia's
Prostatic Specific Antigen (PSA): Prostate screen (MEN ONLY)
Thyroid Stimulating Hormone (TSH): Thyroid Screen
Vitamin D Total, 25-OH: Screening for Vitamin D deficiency
Hemoglobin A1C: Average amount of sugar (glucose) in your blood over the past 2 to 3 months
Hepatitis C W/Reflex: Recommended for participants born between 1945 and 1965. A reflex test will be performed if the Hepatitis C result is positive.

I release the aforementioned persons performing such collection, analysis and reporting from any and all liability for injury or damage associated with the above procedures.
I accept all responsibility for seeking medical treatment from a healthcare provider of my choice in the event of abnormal laboratory results.

- **I understand that payment is due at the time of service.**
- **I understand that the CMMC lab will mail my results to me within a month of my lab draw.**
- **I understand that CMMC will not file my insurance.**
- **I understand I can submit these labs to my insurance.**
- **I understand that these results will NOT automatically be sent to my physician, but my physician may ask for my results to be sent to his/her office.**

Patient Signature: ____Date:__________________

Patients Representative: ____
Relationship Date

Witness: ____Date:__________________

To Be Completed by CMMC: **Amount Paid: $_______** **Check#________** **Mark if Cash______**