2021
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	$20	Complete Metabolic Panel
		11	80061	Z00.00	$20	Lipid Panel
		11	85027	Z00.00	$16	CBC (no Differential)
		11	84153	Z00.00	$36	PSA(Men Only)
		11	84443	Z00.00	$36	Thyroid Test (TSH)
		11	82306	Z00.00	$48	Vitamin D Total, 25-OH
		11	83036	Z00.00	$32	Hemoglobin A1C
		11	86803/87522	Z00.00/Z72.89	$40	Hepatitis C w/reflex if positive
		11	87806	Z00.00/Z72.89	$40	HIV (Human Immunodeficiency Virus)

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
CBC: 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.
HIV 1/2: The virus that causes AIDS. Transmitted through direct contact with HIV-infected body fluids, such as blood, semen, and vaginal fluids, or from a mother who has HIV to her child during pregnancy, labor and delivery, or breastfeeding.

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 2 weeks of my lab draw.**
- **I understand that CMMC will NOT file my insurance; however I can submit these labs to my insurance.**

Initial here if you want your CMMC physician to be able to have access to these results: _____

Patient Signature: _____Date:_____

Patients Representative: _____
Relationship Date

Witness: _____Date:_____

To Be Completed by CMMC: Amount Paid: $_____ Check#_____ Mark if Cash_____