# 2024
## 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 | $22 | Complete Metabolic Panel |
| | | 11 | 80061 | Z00.00 | $22 | Lipid Panel |
| | | 11 | 85027 | Z00.00 | $17 | 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 | $34 | Hemoglobin A1C |

**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

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**

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

**Witness: _____Date:_____**

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