HaysMed Volunteers Community Blood Screening

PLEASE PRINT LEGIBLY Date_____

Last Name_____ First Name_____ Middle Name_____

If under age 18, parent/guardian signature required:_____

Address_____

City_____ State_____ Zip _____

Home Telephone_____ Work Telephone_____ Date of Birth _____ M___ F___

Please circle desired test(s): PROFILE PSA hgA1c Vitamin D

Have you been fasting from food and drink for 10 to 12 hours? □ Yes □ No

- The test(s) results will be mailed to you at the address listed above.
- **Cost: Profile ~ $30.00 PSA ~ $20.00 hgA1c ~ $15.00 Vitamin D ~ $30.00**

Please note the following:

- **HAYS MED WILL NOT SUBMIT A CLAIM TO YOUR INSURANCE COMPANY**
- Screening procedures are not the same as a physical exam by your doctor. Screenings are meant to designate areas that may need further evaluation. It will be your responsibility to contact your healthcare provider for follow up treatment.

CONSENT & RELEASE

I hereby consent to a blood screening as part of Hays Medical Center Volunteers Community Blood Screenings program. This screening is voluntary. I understand that the blood screening results will be mailed to me and that I am responsible for providing my primary care physician with a copy of these results. I understand Hays Medical Center staff may contact me concerning appropriate follow-up care, but is under no obligation to do so.

I understand that I am responsible for my own health. The responsibility for any follow-up examinations to check abnormalities found during this screening lies solely with me and not with Hays Medical Center, any participating organization, or other health care volunteer. I hereby release Hays Medical Center, all other health care volunteers and the sponsoring agencies of this screening program from any and all liability relating to this screening to the fullest extent permitted by law.

I REALIZE IT IS MY RESPONSIBILITY TO SEEK ANY NEEDED CARE.

_____ **I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF HAYS MED'S NOTICE OF PRIVACY PRACTICES.**
(initials)

_____
Signature

HAYSMED VOLUNTEER USE ONLY

Check Amount _____

Cash Received _____

Cash Refund _____

Discounts

HMC _____
(Associate/Volunteer/Quest)

City of Hays _____

$30.00~ Profile _____

$20.00~ PSA _____

$15.00~ hgA1c _____

$30.00 ~Vitamin D _____

Less Discount _____

Total _____

Revised 1/1/2018