



# WALK-IN LAB SERVICES

## QUALITY AND CONVENIENCE

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 (907) 220-99882 (fax) \* info@creeksidehealth.com (email) \* www.creeksidehealth.com

### 1 PERSONAL INFORMATION

Name _____	Today's Date _____
Address _____	
City _____	State _____ Zip _____
Date of Birth _____	Phone _____
Email _____	Social Sec. No. _____
Insurance Provider _____	
Primary Health Care Provider _____	
Allergy Information (please check all that apply): <input type="checkbox"/> Latex <input type="checkbox"/> Alcohol <input type="checkbox"/> Betadine <input type="checkbox"/> Other: _____	

### 2 SELECT TESTS AND PANELS

#### RAPID TESTS (15 minutes)

- A1C (3 month Average Blood Sugar).....\$45.00
- ALT/AST (Liver Function).....\$49.00
- Glucose (Blood Sugars) .....\$21.00
- Pregnancy (Urine or Serum) .....\$30.00
- Cholesterol Panel (HDL/LDL, Chol & Trig).....\$49.00
- Urine Micro Albumin & A:C Ratio .....\$40.00
- UA (Urinalysis).....\$24.00
- Urine Drug Test (11 panel).....\$60.00

#### INDIVIDUAL TESTS

- Blood Type .....\$72.00
- CBC (Complete Blood Count) .....\$27.00
- CMP (Comprehensive Metabolic Panel) .....\$43.00
- FIT (Colorectal Cancer Screening).....\$96.00
- Ferritin .....\$60.00
- Gonorrhea & Chlamydia.....\$192.00
- H. Pylori (Stomach Bacteria) .....\$100.00
- Herpes Simplex Virus (I/II) IgG.....\$275.00
- HIV (Human Immunodeficiency Virus) .....\$50.00
- Iron (Iron Studies).....\$62.00
- Paternity .....\$400.00
- PSA (Prostate Specific Antigen).....\$49.00
- PT/INR (Blood Clotting).....\$49.00

#### INDIVIDUAL TESTS (continued)

- Syphilis.....\$40.00
- TSH (Thyroid Screen).....\$49.00
- Vitamin B-12/Folate .....\$120.00
- Vitamin D25 Hydroxy .....\$120.00

#### LAB PANELS

- Comprehensive Female Panel .....\$530.00  
*(CMP, CBC, Lipid Profile, TSH, Iron Studies, Ferritin, Vitamin D25, and Vitamin B-12/Folate)*
- Comprehensive Male Panel.....\$337.00  
*(CMP, CBC, Lipid Profile, TSH, PSA, & Vitamin D25)*
- Pacific Northwest Regional .....\$645.00  
 Respiratory Allergy Panel
- Childhood Allergy Profile .....\$445.00  
*(Food and Environmental)*
- Adult Food Allergy Profile .....\$384.00
- Value Health Screening Panel.....\$284.00  
*(A1C, Lipid Profile, CMP, CBC, Vitamin D25)*
- Annual Diabetes Management Panel .....\$639.00  
*(A1C, Lipid Profile, CMP, CBC, Vitamin D, TSH, Vitamin B12/Folate, UA with Micro Albumin, Iron Studies, and Ferritin)*
- Thyroid Profile.....\$144.00  
*(TSH, T3 Uptake, T4 Total, FTI)*
- STD Panel.....\$557.00  
*(HIV, Syphilis, Herpes, Gonorrhea & Chlamydia)*

#### OTHER TESTS AND PANELS

Please let us know if you like to order a panel or test not listed here. We'd be happy to assist you choose from hundreds of different options.

- \_\_\_\_\_ \$ \_\_\_\_\_
- \_\_\_\_\_ \$ \_\_\_\_\_
- \_\_\_\_\_ \$ \_\_\_\_\_

**Blood Draw Fee**

**\$ 20.00**

**3 TOTAL**

\$

**4 SIGN RELEASE AND CONSENT FORM (Over)**



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### PATIENT INFORMATION RELEASE AND CONSENT FORM

\_\_\_\_\_ Initial I understand that test results prepared by Creekside Family Health Clinic will be reported directly to me, the manner I have chosen in the "Step 5" box below. I further understand that it is my responsibility to consult a licensed medical provider for interpretation, analysis, evaluation, and explanation of my test results. I understand that neither Creekside Family Health Clinic, or its ordering medical provider, will analyze, evaluate, critique, review or otherwise interpret the results of said tests. I agree that Creekside Family Health Clinic, its employees, employed medical providers, or any agent for the business shall not be liable for any claims including, but not limited, any claim arising out of or related to, inaccurate, un-interpreted, mis-interpreted, or results not received and do hereby expressly forever release and discharge all claims, demands, injuries, damage, actions or causes of action.

\_\_\_\_\_ Initial I agree that I am personally financially responsible for payment of fees for all tests ordered and collected by Creekside Family Health Clinic at my request.

\_\_\_\_\_ Initial I understand that the blood and/or urine tests performed at Creekside Family Health Clinic are done at my request to be screened through either blood and/or urine testing. I further understand that a licensed medical provider under state law to order such testing will do so. I also understand that the actual testing will be performed either on-site or performed by a third party laboratory, certified to perform such testing on my urine and/or blood specimen collected by Creekside Family Health Clinic. I understand and agree that Creekside Family Health Clinic will report the results of the testing directly to me, my physician, or any health professional I request. I consent and authorize that such disclosure may be made by fax, by mail or by direct pick-up. I understand and agree that the services provided by Creekside Family Health Clinic and the tests results from the lab will be maintained as confidential, protected health information by Creekside Family Health Clinic as required by federal and state law.

\_\_\_\_\_ Initial (Optional) I understand that the test results may become part of my medical record. I also understand that an insurance company may discover the results of this testing by obtaining a copy of my medical record in accordance with the terms of my insurance policies. I hereby consent to the release of my urine and/or blood test results by Creekside Family Health Clinic to me in the manner I have chosen in the "Step 5" box and my physician or any other healthcare provider I designate. I understand that my test results will only be provided to other third parties upon my express consent.

\_\_\_\_\_ Initial All of the above has been discussed with me and I have had an opportunity to have any questions answered that I may have regarding my rights to privacy by an employee of Creekside Family Health Clinic. I have received a copy of Notice of Privacy Practices, as required by HIPPA from Creekside Family Health Clinic or have chosen not to receive a copy.

\_\_\_\_\_ Initial I have read and agreed to all of the above terms.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

### 5 CHOOSE PREFERRED METHOD OF RECEIVING THE RESULTS\* (*Choose one*)

US Mail  Pick Up  email  Fax (\_\_\_\_\_) \_\_\_\_\_

*\*All HIV test results must be picked up in person.*

### INTERNAL USE ONLY: (Verification of Results/Letter

US Mail  Pick Up  email  Fax (\_\_\_\_\_) \_\_\_\_\_