Roundup Memorial Healthcare
1202 3rd St. West Roundup, MT 59072
Phone: 406-323-2301
Lab Fax: 406-323-1170

- **DISCOUNT PRICING**
- **NO PHYSICIAN ORDER NEEDED**
- **NO NEED TO REGISTER**
- **PAID AT TIME OF SERVICE**

RMH Direct Lab Order Form

MUST BE 18 YEARS OF AGE TO REQUEST TESTING

NAME (First/MI/Last):______________/____/______________Date of Birth:_______________Gender:(M/F)_______

Address:____City:________________State:______Zip:___________

I request the following laboratory tests and authorize Roundup Memorial Healthcare to complete these tests:

√	Laboratory Test	Cost
	Basic Metabolic Panel	$18
	Blood Type	$21
	CBC	$22
	CBC + Diff	$26
	Cholesterol*	$12
	Cholesterol Panel*	$36
	Comp. Metabolic Panel	$30
	Creatinine (Urine or Blood)	$18
	C-Reactive Protein (CRP)	$18
	FT3	$46
	FT4	$42
	Ferritin	$42

*10-12 hour fasting recommended

√	Laboratory Test	Cost
	Folate	$45
	Glucose	$12
	Hematocrit	$12
	Hemoglobin A1C	$29
	Iron panel w/ TIBC	$72
	Magnesium	$18
	Mono Test	$21
	PSA	$45
	Phosphorous	$16
	Pregnancy Test (Blood or Urine)	$24
	Sed Rate	$18

√	Laboratory Test	Cost
	TSH	$30
	Testosterone, Total	$189
	Uric Acid	$18
	Urinalysis	$22
	Urine Microalbumin	$18
	Urine Micro/Creatinine Ratio	$36
	10-part Urine Tox Screen	$60
	Vitamin D	$66
	Vitamin B12	$42
	Vitamin B12 + Folate	$66

TOTAL DUE: $______________________

By requesting the above laboratory tests, I understand that:

- Laboratory results from RMH are **NOT** a substitute for medical advice, diagnosis, or treatment. You are encouraged to share your results with your primary care provider.
- I should consult a health care provider before I stop, start, or change any treatment plan, including the use of medication. RMH is not responsible for initiating a visit with a health care provider.
- RMH Laboratory employees cannot, by law, interpret Lab Direct test results for me, and I understand that RMH will provide the test results by mail. I should contact my physician to discuss the test results.
- I understand that results within the normal range do not indicate absence of disease.
- I understand that results that fall outside the normal range do not indicate presence of disease.

Please initial each statement:

_____ I understand that RMH will mail my lab test result(s) to the address above. RMH is not responsible for breach of privacy if someone else at the address given above accesses these results. RMH will attempt to reach me directly, at the telephone number given above, if there are results that fall within the abnormal value range as established by RMH policy. If I am not reasonably available at that number, I release RMH from liability related to the inability to contact me by phone.

_____ I understand that RMH lab results can *only* be mailed to the address given and that it is my responsibility to share these results with my provider.

_____ I shall pay RMH in full at the time of service. No other billing will occur to any third party. No refund is available. If am eligible to receive Medicare benefits, I am aware that Medicare does not cover this service and I am fully responsible for payment at this time.

_____ I understand that these test results will be included in my electronic medical record at RMH.

_____ Notice of Privacy Practice (NOPP): My initials acknowledge receipt of the RMH NOPP.

SIGNATURE: ____ ***DATE:*** __________________________