Pathology and Laboratory Medicine
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855.916.4DNA (4362)
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MOLECULAR AND CYTOGENOMICS FINANCIAL RESPONSIBILITY AGREEMENT

Patient Information

Name: ______________________________ **Gender:** M F DOB: MM / DD / YYYY **MRN:** ______________

Date of Service: MM / DD / YYYY ❑ Self- Pay ❑ Retail

Election for Self-Pay or Retail Services and Patient Acknowledgement of Financial Responsibility and Agreement

- I am choosing to waive the use of my health insurance coverage for the testing listed below. No health insurance claim form will be sent to my health insurance company.
- Self-Pay and retail services cannot be reimbursed at any time by my respective insurance carrier(s), nor applied toward my deductible.
- I will receive an invoice and will be held financially responsible for charges associated with the retail services rendered by Henry Ford Center for Precision Diagnostics.
- I have read the above and have had the opportunity to ask any questions about this form. Any questions I may have had about this form have been answered to my satisfaction.

Test(s) ordered: ______________________________ Estimated cost: ______________

Test(s) ordered: ______________________________ Estimated cost: ______________

Test(s) ordered: ______________________________ Estimated cost: ______________

Test(s) ordered: ______________________________ Estimated cost: ______________

My signature below acknowledges the receipt and complete understanding of the Henry Ford Center for Precision Diagnostics Election for Self-Pay or Retail Services and Patient Acknowledgement of Financial Responsibility and Agreement

______________________________ ______________

Signature of Patient or Authorized Designee Date