Billings Clinic

BILLINGS CLINIC EMPLOYEES & SPOUSES

Instructions for offsite clinics and departments:

1. Give original receipt for payment to patient.
2. The following MUST ALL be placed in a LOCKED money bag & returned to Occupational Health, Attn: Laci Johnson: A). Consent form, B). Copy of Lab Log Sheet, C). Cerner Authorization Form, D). Any Cash/Check Payments
3. Return original Lab Log Sheet and blood specimens to Billings Clinic Main Lab

CONSENT FOR BLOOD DRAW, BLOOD PRESSURE, AND BIOMETRIC SCREENING

Employee Number: _____

If you are covered as a spouse on the health plan, you must use "S" followed by the employee number of the **Primary Subscriber on the health plan in order to ensure your receive the additional spouse credit.**

Indicate your current status:

(X)	Employee Status:	Cost
_____	Full time or at least a .50 FTE	$0.00
_____	Per Diem or less than a .5 FTE	$50.00

(X)	Spouse Status:	Cost
_____	Covered on Billings Clinic's health plan	$0.00
_____	Not covered on Billings Clinic's health plan	$50.00

Your Full **LEGAL** Name (please print) _____

Address _____ Date of Birth _____-_____-____ Gender: M / F

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Were you (or your spouse) hired within the last 30 days? Y/N If Yes, please specify date of hire:_____

PLEASE INDICATE (X) ADDITIONAL TESTS YOU WOULD LIKE TODAY (TO BE PAID AT TIME OF SERVICE):

	Vitamin D	**$25.00**
	Hemoglobin A1c	**$25.00**
	PSA	**$35.00**

At my request, I consent to a venipuncture and the performance of laboratory testing on my blood sample. I understand that laboratory results are NOT a substitute for medical advice, diagnosis or treatment, and it is my responsibility to share my results with my primary care provider. I should consult a physician before I stop, start, or change any treatment plan, including use of medication. Billings Clinic is not responsible for initiating a visit with a physician or other health care provider. I understand that results within normal range do not indicate absence of disease, and results that fall outside of normal range do not indicate the presence of disease. I understand Billings Clinic will mail my lab test results to the address I provided. Billings Clinic is not responsible if someone else at that address accesses the lab results. Billings Clinic will notify me in writing or by telephone at the telephone number provided if the abnormal results fall within criteria established by Billings Clinic Employee Health. If I am not reasonably available at that number, I release Billings Clinic from liability related to the inability to contact me by telephone.

My signature acknowledges that I have read and understand the Consent listed above. I have also been given the opportunity to review Billings Clinic's Notice of Privacy Practices (NOPP).

Signature _____**Date**_____ **Time**_____

VENIPUNCTURE DOCUMENTATION *(for Employee Health assigned staff only)*: Please indicate by circling appropriate site drawn:

L A C	R A C	R Hand	L Hand	Other:

Were there multiple attempts? If so, how many?_____Please document complications:_____

_____

Signature (phleb):_____Date/Time:_____

Date Mailed:_____Was patient contacted? (Y/N)_____(if yes please attach progress note) Rev7/29/2015-smc