Consent Form

BLACK HILLS SURGICAL HOSPITAL
The choice that makes a difference.
Proudly owned by physicians

Please complete this form prior to your appointment and bring it with you.

Name: _____

Mailing Address: _____

Home #: _____ Work #: _____ Cell #: _____

Email address: _____

Date of Birth: _____ / _____ / _____ Gender: Male _____ Female _____

Requested laboratory tests:

	Test	Cost	Code
	Blood type (ABO/RH)	$14.00	006049
	Calcium	$12.00	001016
	Carcinoembryonic antigen (CEA)	$25.00	002139
	Cardiac Risk - comprehensive panel	$75.00	370881
	Cholesterol / Lipid panel	$20.00	221010
	Complete Blood Count (CBC)	$12.00	005009
	Comprehensive Metabolic Panel	$15.00	322000
	Diabetes Management Panel	$30.00	102558
	Ferritin	$25.00	004598
	Folate	$25.00	002014
	GGT	$10.00	001958
	Glucose	$10.00	001032
	Hemoglobin A1c	$25.00	001453
	Hepatic Panel	$20.00	322755
	Hepatitis A	$35.00	006726
	Hepatitis B Immunity	$35.00	006395
	Hepatitis B Panel	$50.00	098418
	Hepatitis C	$40.00	140659
	Hepatitis Profile (A, B Panel and C)	$100.00	322744
	High Sensitivity C-Reactive Protein	$30.00	120766
	HIV	$35.00-$135.00	083824
	Homocysteine	$45.00	706994
	Iron	$9.00	001339
	Iron and TIBC	$25.00	001321

	Test	Cost	Code
	Magnesium	$10.00	001537
	MMR Immunity Panel	$50.00	058495
	Mononucleosis	$15.00	006189
	Phosphorous	$10.00	001024
	Pregnancy Test (serum)	$20.00	004556
	Prostate-Specific Antigen (PSA)	$25.00	010322
	PTH	$40.00	015610
	RBC Folate	$35.00	266015
	T3 Free	$40.00	010389
	Testosterone	$45.00	004226
	Thyroid Screen	$60.00	376137
	TSH	$20.00	004259
	Uric Acid	$10.00	001057
	Urinalysis	$12.00	003384
	Vitamin A	$45.00	017509
	Vitamin B-1	$25.00	121178
	Vitamin B12	$25.00	001503
	Vitamin B12 and Folate	$30.00	000810
	Vitamin C	$45.00	001479
	Vitamin D, 25-Hydroxy	$50.00	081950
	Wellness Profile for Men	$70.00	323846
	Wellness Profile for Senior Men	$150.00	370796
	Wellness Profile for Women	$125.00	363627

Total Amount Due: $_____

I would like my results sent via: ☐ Mail ☐ Email ☐ Fax #:_____ ☐ I will pick up

Primary Care Physician (optional): _____ Send results to him/her: ☐Yes ☐ No

If you do not have a primary care physician would you like us to refer you to one? ☐ Yes ☐ No

Must be at least 18 years old or be accompanied by a parent or guardian.

Signature: _____ Date: _____

Authorized Representative Signature: _____ Relationship: _____

Witness: _____ Date: _____