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| **Patient****Information** | **First Name** | **Last Name** |
| **Address** | **Date of Birth Gender** **M F** |
| **City** | **Last four digits****Social Security Number** |
| **State Zip Code** | **Phone** |
| **Email Address:** | **Date of application:** |

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| **Payment information** | **Payment Method: Payments are accepted through Square and personal check. A link will be sent to your email for payment upon receipt of this order form. Please indicate your method of payment.****Check Enclosed** **Emailed Invoice** **For square payments, please confirm your email address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **Patient signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **Patient consent** | **I have requested discount lab services from the PALS organization. I understand that I am responsible for****Physician follow-up, treatment plan, medications, and further testing. I also understand that testing is confidential and no information provided would make it possible for identification will be included in any reports.** **Patient Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |

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| **Lab work information** | **Test Code** | **Test name** | **Fee** |
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| 4989 |  Processing Fee | $15.00 |
| **Total number of labs**  |  | **Amount Enclosed** |

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| --- | --- |
| **Physician****information** | Physician’s Name NPI # |
| Contact Number Fax # |
| I have ordered the above indicated lab tests to be performed for this patient and attest the information provided is complete and accurate to the best of my knowledge. Physician signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Mail Form to**: 4329 State Road H OR **Fax form to**: 573-442-6736 Attn: PALS

 Fulton, MO 65251

Thank you for using PALS