PATIENT WAIVER FOR FINANCIAL ASSISTANCE

Please send completed form with the test requisition
OR fax it at the time of sample collection to 1-855-647-4363

I, _____,
have been notified that I do not meet the guidelines for medical necessity for the _____ test order by my provider and that because I do not meet these guidelines, my insurance would likely deny my claim. In light of this information, I still want to pursue testing and agree to:

Pay the full cost (cash price) of the ordered test, payable in installments.
Pay a lump sum of _____, without installments.

_____ _____
Patient Signature Date