2817 Miller Ranch Road, Unit 317
Pearland, Texas, 77584
Billing Phone Number: 844-442-8420

# PATIENT CONSENT FORM

I voluntarily consent to the collection and testing of my specimen. I certify that the specimen on this form is my own, and that the specimen is fresh and free from any adulteration. I certify that the information provided to the clinic and on the label of the specimen bottle is accurate.

I UNDERSTAND THAT PAYMENT OF AUTHORIZED INSURANCE WILL BE MADE ON MY BEHALF TO APC HEALTH LLC, FOR THE SERVICES BEING FURNISHED TO ME BY APC HEALTH LLC. I UNDERSTAND THAT I AM FREE TO USE THE LAB OF MY CHOICE AND SUCH CHOICE WILL NOT IMPACT THE CARE PROVIDED. I acknowledge that APC Health LLC may be an out-of-network facility with my insurance provider.

I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE IT TO THE INSURANCE COMPANY AND ITS AGENTS IF NEEDED TO DETERMINE BENEFITS PAYABLE FOR THE SERVICES I RECEIVE. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered valid.

I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY SAID INSURANCE. I am also aware that in some circumstances my insurance provider will send the payment directly to me for services provided. Under Law, I agree to endorse the insurance check and forward it to APC Health LLC, within 30 days of receipt.

I authorize APC Health LLC, to release the results of the test performed to the ordering facility/physician.

Print Name: _____________________________ Date of Birth: _________________________

Signature: __________________________________________________________________________________

Date: ______________________________________________________________________________________