WAVERLY HEALTH CENTER

«Last_Name», «First_Name»	**DOB:** «Birth_Date»
MR#: «Medical_Record_Number»	**VISIT ID#:** «Visit_ID»
SEX: **AGE:** «Age»	**HSV:** «Service_Code»
ADMIT: «Admit_Date»	**RM/BED:**

Courtesy Lab Draw

Monday-Friday 7:30 a.m. - 4:00 p.m.

Name: _____ Daytime Phone: _____

Date of Birth: _____ Sex: □ M □ F

Time Drawn: _____ Tech: _____

Courtesy Lab Draw (CDRAW)	**Cost: $50**	**Your insurance company will not be billed. Accepted payment types are:** **_____ Cash _____ Check _____ Credit Card**

Consent statement:

- I understand that Waverly Health Center is providing a courtesy service and the follow up of these tests and test results are my responsibility.
- I understand that the Waverly Health Center laboratory will collect, process, and ship the specimens to the best of their ability.
- I release Waverly Health Center from any liability with respect to the test results provided.

Participant's Signature: _____ Date: _____