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## Carrier Screening Self-Pay Patient Agreement

Patient's Name (please print)	Insured/Guarantor Name (if different from patient)
Insurance company	Member ID Number

We are notifying you that your insurance company, \_\_\_\_\_, may not cover the service(s) described below. The fact that they may not cover a particular service does not mean that you should not receive it. Based on your profile, your healthcare provider recommends this testing.

TEST CODE	DESCRIPTION	PRICE
<input type="checkbox"/> CARR	CARRIER SCREENING TEST (INCLUDES CFXZ, SMA, FX)	\$450.00
<input type="checkbox"/> CFXZ	CYSTIC FIBROSIS	\$250.00
<input type="checkbox"/> SMA	SPINAL MUSCULAR ATROPHY	\$100.00
<input type="checkbox"/> FX	FRAGILE X SYNDROME PANEL	\$100.00

Doctor's Note: \_\_\_\_\_

**Reasons why charges may be denied:**

- It is a non-covered item or service, your insurance company will not pay
- The service is considered experimental or for research use and is not covered
- Other (explain): \_\_\_\_\_

- At this time I have no health insurance coverage or lab may be out of network or my insurance company does not pay for the test(s). I understand that I am responsible for paying all the charges for the lab services performed.
- I received the self-pay agreement policy from ACCU Reference Medical Lab. I have read and fully understand the information provided to me.
- If I have any questions about my charges, statements or balance due, I understand that I may contact **ACCU Reference Medical Lab's Billing Department at 908-474-1004.**

Patient signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_