ADVANCED LAB SOLUTIONS

CLIA# 39D2175506

Cardiomyopathy & Arrhythmia Genetic Panel Test

Patient Name:

Patient Acknowledgement: I acknowledge that the information provided by me is true to the best of my knowledge. For direct insurance/3rd party billing: I hereby authorize my insurance benefits to be paid directly to and authorize them to release medical information concerning my testing to my insurer. If applicable, I authorize to be my Designated Representative for purposes of appealing any denial of benefits. I acknowledge and agree that has the right to request additional medical records, such as consult notes, pedigrees, and clinical/family history notes directly from my provider(s) for the purpose of insurance verification and proper billing. I also fully understand that I am legally responsible for sending any money received from my health insurance company for performance of this genetic test. For patient payment by credit card: I hereby authorize to bill my credit card as indicated above.

Patient Signature:_____Date:_____

indications for testing (check all that apply)

ICD-10 Code (s):

Other:

tests requested

Cardiovascular Diseases Gene Panel genes tested