



# TEST REQUISITION AND PAYMENT FORM

3000 First Ave. Ste. One, Seattle, WA 98121

Phone: 800-523-6487 Fax: 206-219-4000 CLIA # 50D0980559 NPI # 1760523856

Account Bill  Insurance Bill  Patient Bill Medical Account Code:

## Patient Payment and Insurance Information

Last Name		First Name		MI	Collection Date:
Street Address			City	State	Zip
Home Phone		Work/Cell Phone		Email	
DOB	Height	Weight	Name on Card		
For Patient Bill Only	Payment: <input type="checkbox"/> Money Order <input type="checkbox"/> Check <input type="checkbox"/> Credit Card			Expiration Date	Cardholder Signature
	Card Number:				

### Complete insurance section below only if NOT attaching back and front copies of insurance card

Medicare Number: Relationship to Insured: Self  Spouse  Dependent

<b>PRIMARY</b>	Print Name of Insured As It Appears on Insurance Card			<b>SECONDARY</b>	Print Name of Insured As It Appears on Insurance Card		
	Primary Insurance Company Name				Secondary Insurance Company Name		
	Member/Insured ID #	Group #			Member/Insured ID #	Group #	
	Insurance Address				Insurance Address		
	City	State	Zip		City	State	Zip

## Physician Ordering Test

Physician Name		<b>Duplicate Reports To</b>			
Phone	Fax/Email	Last Name	First Name	MI	
Facility Name and Address		Street Address, City, State, Zip			
NPI #	ICD9 Code	Preferred Phone	Fax/Email		
Physician Signature		Send copy to patient? <input type="checkbox"/> Yes <input type="checkbox"/> No			

### Test Menu

### Sample Submission Checklist

<input type="checkbox"/> CYP2D6	<input type="checkbox"/> CYP2C9/VKORC1 (warfarin)	<input type="checkbox"/> Included ICD9 Code
<input type="checkbox"/> CYP2C9	<input type="checkbox"/> VKORC1	<input type="checkbox"/> Requested Tests
<input type="checkbox"/> CYP2C19	<input type="checkbox"/> UGT1A1	<input type="checkbox"/> Copy of both sides of insurance card
<input type="checkbox"/> CYP1A2	<input type="checkbox"/> DPD	<input type="checkbox"/> Patient Signature
<input type="checkbox"/> NAT2	<input type="checkbox"/> Nutritional Genetic Panel	<input type="checkbox"/> Physician Signature

### STATEMENT OF CONSENT AND RELEASE (Patient or legal guardian of patient must sign)

I hereby certify that the information provided is true and accurate and that I have authority to order this testing. I consent to the collection of specimens from myself or my minor child for the purpose of DNA testing. I understand that while DNA testing is highly accurate and widely accepted, as in all testing there is a possibility of delay or error. I understand that this testing is for informational purposes. I understand that prescription drug regimens should never be altered without consulting a prescribing medical professional. I understand that these results are being collected and furnished by Genelex, and that Genelex reserves the right to send these specimens to outside laboratories for confidential DNA analysis. Genelex will not release any personal, identifiable information of any kind to a third party without my express written instructions. I also understand that Genelex reserves the right to provide de-identified information of a statistical nature to accrediting agencies and reserves the right to use such anonymous information for research purposes. I understand that Genelex may require more specimens for testing, and will contact me to obtain more specimens. By submitting specimens to Genelex, I agree to relinquish Genelex and its representatives, from any and all injury, physical or psychological, that might arise from collecting and testing these specimens and from any effects or actions that the results of these tests may have on myself or any other individual. I understand that I will be held responsible for payment of testing fees, including any necessary cost of collection and reasonable attorney fees. This agreement for testing is subject to and shall be construed and enforced in accordance with the laws of the State of Washington. Genelex Corporation's limit of liability is not to exceed the cost of the testing. I allow Genelex to release customer data to outside third parties to assist in the collection of any unpaid fees. Testing fees are not refundable after testing has started or after 180 days from order date. Results will not be released until payment is received and this statement is signed.

Signature of tested adult or legal guardian of tested child if under 18

Date