REGIONAL MEDICAL LABORATORY

PATIENT AGREEMENT

Financial Responsibility

I understand that, ultimately, regardless of whether I have insurance, I am financially responsible for any and all charges for any and all services rendered to me. If I do have insurance, I understand that Regional Medical Laboratory may not be participating in my insurance or health plan. I hereby assign to Regional Medical Laboratory all my rights, title, and interest to medical expense reimbursement benefits under any insurance policy, subscription certificate, Medicare Benefits, or any other public or private health care benefit indemnification program or agreement otherwise payable to me for those services rendered. I further authorize Regional Medical Laboratory to release any of my medical records reasonably requested by my insurer or other payer and their agents to process payment.

I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance. I understand and agree that it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements, or any other type of benefit limitation for the services I receive, and I agree to make payment in full. I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain the referral. I understand that without this referral my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to inform Regional Medical Laboratory of any changes in my insurance coverage. If I don't have insurance or if my insurance changes or terminates at the time of service, I understand that I am financially responsible for the balance in full and agree to pay any established rates of Regional Medical Laboratory. I also agree that Regional Medical Laboratory may transfer any monies held in a different credit balance account in my name to satisfy these charges, if necessary. I acknowledge consent for Regional Medical Laboratory, its providers and agents, including debt collectors, to place calls to my cellular and/or residential phone using artificial or pre-recorded voice or auto-dialer technologies for any permissible purpose, including debt collections and/or account verification.

Uninsured/Underinsured Patient Discount Policy

It is the policy of Regional Medical Laboratory to provide financial assistance to individuals who have a demonstrated need. For information regarding the financial assistance program, please call (918) 744-2164.

Patient Demographics and Insurance information

I confirm the demographic information, including my address and insurance information, is correct. I understand incorrect information may result in a claim not being filed to my insurance plan and I will be responsible for the balance.

Reflex Testing

I understand additional testing may be performed due to reflex testing. Reflex testing means the results of the initial test triggered additional tests to be automatically ordered to render a diagnosis.

I certify I have read and agree to each of the above statements.

Patient Name Patient Date of Birth

Patient/Guarantor Signature Guarantor Name (if different from the patient) Date