Boone County Health Center
Dedicated. Caring. Here.

KNOW YOUR NUMBERS Consent Form

PLEASE PRINT LEGIBLY.

LAST NAME: _____

FIRST NAME: _____ MIDDLE INITIAL: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: _____

DATE OF BIRTH: _____

MALE: ( ) FEMALE: ( )

PLEASE CHECK ONE:

☐ **I will receive my results via the BCHC Portal.** *Results will be available within 24 hours.*

☐ **I want my results mailed to me.** *Results will be mailed within 7-10 days.*

- **Bring $65.00 cash/check (*payable to BCHC*) with you the day of your appointment.**
- **Add $25.00 if Vitamin D was elected. This had to be elected at time of making appointment.**

CONSENT AND RELEASE: I hereby consent to the drawing of a blood sample for the purpose of measuring blood screening. I release Boone County Health Center, its employees, agents, directors and assignees from any and all liability arising from this blood draw. I understand that the results of these tests are preliminary and do not constitute a diagnosis. I also understand that it is my responsibility to obtain professional medical assistance with the results of these tests.
My signature also indicates that this lab draw will not be submitted to insurance.

SIGNATURE: _____ DATE: _____

BCHC use only:

☐ **Lab Draw** ☐ **Flu Shot: Insurance Card or Payment**

☐ **Cash** ☐ **Check#: _____** **FIN#: _____**