All American Ob/Gyn
413 Owen Drive Suite 101
Fayetteville, NC 28304
910-480-4880

CONSENT TO LAB TREATMENT/FINANCIAL AGREEMENT

I agree that I am responsible for payment of all charges for health care services provided to me by **LabCorp** or **Quest Diagnostic Laboratories** here at All American OB/GYN. If applicable, I understand that an insurance card is necessary to validate my coverage for each visit. If I do not have my card with me, I accept financial responsibility for all services provided to me by these laboratories and in the event that I am not covered for these services, I understand that I will receive a bill for these services from **LabCorp** or **Quest.** Some labs if tested positive results in additional reflex tests being done i.e. PAP, HIV and Hepatitis C. I understand that if I test positive for one of these tests and is given a reflex test I accept responsibility for all bills created from this lab.

Patient Signature: ____
(Or parent, or legal guardian)

Print Name: ____

Date: ____