Patient Responsibility **(include with request form or FAX/e-Mail to Allermetrix)**

Name Last: _____ Date of Birth ____ ____ ____

Name First: _____

Address: _____

City: _____ State: _____ Zip:_____

I understand that if I elect to receive the services and my healthcare insurance company determines that the services are part of my Deductible, Coinsurance, Out-of-Network, are Investigational Services, are not Covered Services, are not considered to be Medically Necessary or Medically Appropriate:

I will be responsible to pay for all costs associated with the laboratory services that are not paid by my insurance policy. I authorize the use of my credit/HSA card and understand that I will be informed of the costs prior to Allermetrix withdrawing funds via my payment choice indicated below:

Patient Signature: X _____

◯ Call me for credit card information

Phone: _____-_____-_____

Best time to call: _____

Credit Card Type: ◯ Visa ◯ Mastercard ◯ Discover ◯ American Express

Is this a Healthcare card (FSA HSA HRA): ◯ Yes ◯ No

Number: _____ Exp Date: _____/_____

CVV (3 digit security code on back of card): _____

Telephone: 877-992-4100 Fax: 615-599-4648 e-Mail: info@allermetrix.com