

5110 Campus Drive, Suite #150 | Plymouth Meeting, PA 19462 T: 610-441-9050 | F: 610-537-5075 | E: info@fratnow.com | https://fratnow.com

FACILITY INFORMATION (PLEASE PRINT IN BLUE or BLACK INK)

Physician Name:		<u> </u>				-						
Street: Email:	Physician Name:	Specimen Ty	imen Type: Date Specimen Time Specimen		Time Spec	cimen						
City: State: ZIP: Country: NPT #: Diagnosis: Diagnosis: Diagnosis: Diagnosis Code(s): Preferred method for receiving results: Email	Facility Name:					Telephone:	Telephone: Secure Fax:					
Diagnosis: Diagnosis Code(s):	Street:					Email:	Email:					
Preferred method for receiving results: Email Fax Other Direct Bill Account Number: Physician acknowledgement: I hereby confirm that the information, including the information related to medical necessity as provided on this form, has been provided to the patient specified below and/or their legal guardian has byten consent for the test(s) to be performed, and the patient specified below and/or their legal guardian has given consent for the test(s) to be performed, and the patient specified below and/or their legal guardian has given consent for the test(s) to be performed. I confirm that the person listed as the ordering physician who has signed below is authorized by law to order the test(s) requested herein. Physician Signature: Date: Date: Patient First Name: Patient Last Name: Responsible Party (if other than the patient): Patient First Name: Patient Last Name: Relationship to Patient: Street: Zip: State: Zip: City: State: Zip: Telephone: - Telephone: PLEASE NOTE: PATIENTS MUST NOT TAKE FOLINIC ACID OR S-MTHF FOR 48 HOURS PRIOR TO BLOOD DRAW. PAYMENT INFORMATION Cost of FRAT® testing is \$295 Bill to: Amex Visa Mastercard Discover Check enclosed made payable to Religen, Inc. PIREASE NOTE: CREDIT CARD or CHECK PAYMENT MUST BE RECEIVED PRIOR TO TESTING. PATIENT CONSENT & AUTHORIZATIONS Patient acknowledgment: My healthcare provider has provided me with information regarding the tests requested on this form. I agree that I am voluntarily submitting this sample for analysis. I authorize my physician to release the sample and any other necessary records as requested to Religen Inc. and for Religen Inc. to release the results of FRAT® testing by sample for analysis. I authorize my physician to release the sample and any other necessary records as requested to Religen Inc. and for Religen Inc. to release the results of FRAT® testing by sample for analysis. I authorize my physician to release the sample and any other necessary records as requested t	City:	State:	te: ZIP:		Country:	NPI #:						
Pretered method for receiving results: Email Fax Other Physician acknowledgement. I hereby confirm that the information, including the information related to medical necessity as provided on this form, has been provided to the patient specified below and/or their legal guardian about the test(s) to be performed, and the patient specified below and/or their legal guardian has given consent for the test(s) requested herein. Physician Signature: Title: Date: PATIENT INFORMATION Patient First Name: Patient Last Name: Responsible Party (if other than the patient): Patient First Name: Patient Last Name: Responsible Party (if other than the patient): Street: Street: Street: City: State: Zip: City: State: Zip: City: State: Zip: Telephone: PLEASE NOTE: PATIENTS MUST NOT TAKE FOLINIC ACID OR 5-MTHF FOR 48 HOURS PRIOR TO BLOOD DRAW. PAYMENT INFORMATION Cost of FRAT® testing is \$295 Bill to: Amex Visa Mastercard Discover Check enclosed made payable to Religen, Inc. Print Name on Card: Expiration Date: PLEASE NOTE: CREDIT CARD or CHECK PAYMENT MUST BE RECEIVED PRIOR TO TESTING. PATIENT CONSENT & AUTHORIZATIONS PATIENT CONSENT & AUTHORIZATIONS PATIENT CONSENT & AUTHORIZATIONS Patient acknowledgment: My healthcare provided he with information regarding the tests requested on this form. I agree that I am voluntarily submitting this sample for analysis. I authorize my physician to release the semple and any other necessary records as requested to Religen Inc. and for Religen Inc. to release the results of FRAT® to the ordering physician. I understand that I am responsible for all charges for FRAT® testing.	Diagnosis:	Diagnosis Code(s):										
been provided to the patient specified below and/or their legal guardian about the test(s) to be performed, and the patient specified below and/or their legal guardian has given consent for the test(s) to be performed. I confirm that the person listed as the ordering physician who has signed below is authorized by law to order the test(s) requested herein. Physician Signature:	Preferred method	Direct Bill Acc	Direct Bill Account Number:									
Patient First Name: Patient Last Name: Patient Last Name: Responsible Party (if other than the patient):	Physician acknowledgement: I hereby confirm that the information, including the information related to medical necessity as provided on this form, has been provided to the patient specified below and/or their legal guardian about the test[s) to be performed, and the patient specified below and/or their legal guardian has given consent for the test[s) to be performed. I confirm that the person listed as the ordering physician who has signed below is authorized by law to order the test(s) requested herein.											
Patient First Name: Patient Last Name: Responsible Party (if other than the patient): POB: Relationship to Patient: Street: Street: City: State: Zip: Telephone: PLEASE NOTE: PATIENTS MUST NOT TAKE FOLINIC ACID OR 5-MTHF FOR 48 HOURS PRIOR TO BLOOD DRAW. PAYMENT INFORMATION Cost of FRAT® testing is \$295 Bill to: Amex Visa Mastercard Discover Check enclosed made payable to Religen, Inc. Print Name on Card: Credit Card Number: Security Code (CVV): Billing Zip Code: PLEASE NOTE: CREDIT CARD or CHECK PAYMENT MUST BE RECEIVED PRIOR TO TESTING. PATIENT CONSENT & AUTHORIZATIONS Patient acknowledgment: My healthcare provider has provided me with information regarding the tests requested on this form. I agree that I am voluntarily submitting this sample for analysis. I authorize my physician to release the sample and any other necessary records as requested to Religen Inc. and for Religen Inc. to release the results of FRAT® to the ordering physician. I understand that I am responsible for all charges for FRAT® testing.	Physician Signat	Tille.	Ittle: Date:									
DOB:	PATIENT INFORI	MATION										
Street: City: State: Zip: City: State: Zip: Telephone: PLEASE NOTE: PATIENTS MUST NOT TAKE FOLINIC ACID OR 5-MTHF FOR 48 HOURS PRIOR TO BLOOD DRAW. PAYMENT INFORMATION Cost of FRAT® testing is \$295 Bill to: Amex Visa Mastercard Discover Check enclosed made payable to Religen, Inc. Print Name on Card: Expiration Date: Security Code (CVV): Billing Zip Code: Email to send receipt to: PLEASE NOTE: CREDIT CARD or CHECK PAYMENT MUST BE RECEIVED PRIOR TO TESTING. PATIENT CONSENT & AUTHORIZATIONS Patient acknowledgment: My healthcare provider has provided me with information regarding the tests requested on this form. I agree that I am voluntarily submitting this sample for analysis. I authorize my physician to release the sample and any other necessary records as requested to Religen Inc. and for Religen Inc. to release the results of FRAT® to the ordering physician. I understand that I am responsible for all charges for FRAT® testing.	Patient First Name:			Patient La	st Name:		Responsible Party (if other than the patient):					
Street: City: State: Zip: City: State: Zip: Telephone: PLEASE NOTE: PATIENTS MUST NOT TAKE FOLINIC ACID OR 5-MTHF FOR 48 HOURS PRIOR TO BLOOD DRAW. PAYMENT INFORMATION Cost of FRAT® testing is \$295 Bill to: Amex Visa Mastercard Discover Check enclosed made payable to Religen, Inc. Print Name on Card: Expiration Date: Billing Zip Code: Email to send receipt to: PLEASE NOTE: CREDIT CARD or CHECK PAYMENT MUST BE RECEIVED PRIOR TO TESTING. PATIENT CONSENT & AUTHORIZATIONS Patient acknowledgment: My healthcare provider has provided me with information regarding the tests requested on this form. I agree that I am voluntarily submitting this sample for analysis. I authorize my physician to release the sample and any other necessary records as requested to Religen Inc. and for Religen Inc. to release the results of FRAT® to the ordering physician. I understand that I am responsible for all charges for FRAT® testing.	DOB: ☐ Male ☐ Female						Relationship to Patient:					
Telephone: PLEASE NOTE: PATIENTS MUST NOT TAKE FOLINIC ACID OR 5-MTHF FOR 48 HOURS PRIOR TO BLOOD DRAW. PAYMENT INFORMATION Cost of FRAT® testing is \$295 Bill to:							Street:					
PAYMENT INFORMATION Cost of FRAT® testing is \$295 Bill to:	City:		State:		Zip:	City:		State:		Zip:		
PAYMENT INFORMATION Cost of FRAT® testing is \$295 Bill to: Amex Visa Mastercard Discover Check enclosed made payable to Religen, Inc. Print Name on Card: Expiration Date: Security Code (CVV): Billing Zip Code: Billing Zip Code: PLEASE NOTE: CREDIT CARD or CHECK PAYMENT MUST BE RECEIVED PRIOR TO TESTING. PATIENT CONSENT & AUTHORIZATIONS Patient acknowledgment: My healthcare provider has provided me with information regarding the tests requested on this form. I agree that I am voluntarily submitting this sample for analysis. I authorize my physician to release the sample and any other necessary records as requested to Religen Inc. and for Religen Inc. to release the results of FRAT® to the ordering physician. I understand that I am responsible for all charges for FRAT® testing.	Telephone:					!	Telephone:				<u>.</u>	
Bill to: Amex Visa Mastercard Discover Check enclosed made payable to Religen, Inc. Print Name on Card: Expiration Date: Security Code (CVV): Billing Zip Code: Email to send receipt to: Billing Zip Code: PLEASE NOTE: CREDIT CARD or CHECK PAYMENT MUST BE RECEIVED PRIOR TO TESTING. PATIENT CONSENT & AUTHORIZATIONS Patient acknowledgment: My healthcare provider has provided me with information regarding the tests requested on this form. I agree that I am voluntarily submitting this sample for analysis. I authorize my physician to release the sample and any other necessary records as requested to Religen Inc. and for Religen Inc. to release the results of FRAT® to the ordering physician. I understand that I am responsible for all charges for FRAT® testing.	PLEASE NOTE: PATIENTS MUST NOT TAKE FOLINIC ACID OR 5-MTHF FOR 48 HOURS PRIOR TO BLOOD DRAW.											
Bill to: Amex Visa Mastercard Discover Check enclosed made payable to Religen, Inc. Print Name on Card: Expiration Date: Expiration Date: Security Code (CVV): Billing Zip Code: Email to send receipt to: PLEASE NOTE: CREDIT CARD or CHECK PAYMENT MUST BE RECEIVED PRIOR TO TESTING. PATIENT CONSENT & AUTHORIZATIONS Patient acknowledgment: My healthcare provider has provided me with information regarding the tests requested on this form. I agree that I am voluntarily submitting this sample for analysis. I authorize my physician to release the sample and any other necessary records as requested to Religen Inc. and for Religen Inc. to release the results of FRAT® to the ordering physician. I understand that I am responsible for all charges for FRAT® testing.	PAYMENT INFORMATION											
Print Name on Card:	Cost of FRAT® testing is \$295											
Credit Card Number:	Bill to: ☐ Amex ☐ Visa ☐ Mastercard ☐ Discover ☐ Check enclosed made payable to Religen. Inc.											
Credit Card Number:	Print Name on Car	d:										
Security Code (CVV):												
PLEASE NOTE: CREDIT CARD or CHECK PAYMENT MUST BE RECEIVED PRIOR TO TESTING. PATIENT CONSENT & AUTHORIZATIONS Patient acknowledgment: My healthcare provider has provided me with information regarding the tests requested on this form. I agree that I am voluntarily submitting this sample for analysis. I authorize my physician to release the sample and any other necessary records as requested to Religen Inc. and for Religen Inc. to release the results of FRAT® to the ordering physician. I understand that I am responsible for all charges for FRAT® testing.	Credit Card Number		Expiration Date:									
PATIENT CONSENT & AUTHORIZATIONS Patient acknowledgment: My healthcare provider has provided me with information regarding the tests requested on this form. I agree that I am voluntarily submitting this sample for analysis. I authorize my physician to release the sample and any other necessary records as requested to Religen Inc. and for Religen Inc. to release the results of FRAT® to the ordering physician. I understand that I am responsible for all charges for FRAT® testing.	Security Code (CVV): Billing Zip Code:											
PATIENT CONSENT & AUTHORIZATIONS Patient acknowledgment: My healthcare provider has provided me with information regarding the tests requested on this form. I agree that I am voluntarily submitting this sample for analysis. I authorize my physician to release the sample and any other necessary records as requested to Religen Inc. and for Religen Inc. to release the results of FRAT® to the ordering physician. I understand that I am responsible for all charges for FRAT® testing.	Email to send receipt to:											
Patient acknowledgment: My healthcare provider has provided me with information regarding the tests requested on this form. I agree that I am voluntarily submitting this sample for analysis. I authorize my physician to release the sample and any other necessary records as requested to Religen Inc. and for Religen Inc. to release the results of FRAT® to the ordering physician. I understand that I am responsible for all charges for FRAT® testing.	PLEASE NOTE: CREDIT CARD or CHECK PAYMENT MUST BE RECEIVED PRIOR TO TESTING.											
Patient acknowledgment: My healthcare provider has provided me with information regarding the tests requested on this form. I agree that I am voluntarily submitting this sample for analysis. I authorize my physician to release the sample and any other necessary records as requested to Religen Inc. and for Religen Inc. to release the results of FRAT® to the ordering physician. I understand that I am responsible for all charges for FRAT® testing.	PATIENT CONSENT & AUTHORIZATIONS											
submitting this sample for analysis. I authorize my physician to release the sample and any other necessary records as requested to Religen Inc. and for Religen Inc. to release the results of FRAT® to the ordering physician. I understand that I am responsible for all charges for FRAT® testing.												
PATIENT/PARENT/GUARDIAN SIGNATURE: Date:	submitting this sample for analysis. I authorize my physician to release the sample and any other necessary records as requested to Religen Inc. and for											
	PATIENT/PARENT	T/GUARDIAN SIGN	IATURE	:					Date: _			

Powered By:

