ACCOUNT INFORMATION

I authorize the laboratory test(s) as ordered, and affirm that each are both medically necessary and correspond to the patient's diagnosis as submitted to the laboratory for testing. I understand that each test I order is a billable event and the patient's medical record(s) must clearly reflect my order.

Ordering Physician Signature (Required) Date

Collection Date and Time: ______/______/______ ❑ AM ❑ PM

Collector's Name and Initials ______________________________

RESPIRATORY PANEL ORDERED *See panel details on reverse

❑ **Respiratory Pathogen Panel[1]***

❑ **Respiratory Pathogen Panel w/ COVID 19 (SARS-CoV-2[2])***

❑ **COVID 19 (SARS-CoV-2)**

BILLING INFORMATION

❑ Insurance ❑ Medicare ❑ Medicaid

❑ Client Bill ❑ Self Pay ❑ Worker Comp

Insurance Plan ______________________________

Policy # ______________________________

Policy Phone Number ______________________________

MANDITORY ICD10 CODES

____

____

____

____

RESPIRATORY PATHOGEN REQUISITION

8601 Dunwoody Pl Ste 444
Atlanta, GA 30350
Phone: 844.497.8851 Fax: 470.355.5462
Email: clientservice@capstonehealthcare.com

PATIENT INFORMATION

Attach Copy of the Patient's Face Sheet

Name: ______________________________
Last First Middle

Address: ______________________________

____
City State Zip Code

Date of Birth: ______/______/______ Sex ❑ Male ❑ Female

Social Security #: __________ - __________ - __________

Phone #: ______________________________

I understand that Capstone Healthcare, LLC is **NOT** a specimen banking facility and my sample will **NOT** be available after 60 days or for future clinical studies. De-identified samples may be stored in a repository and used internally for validation, educational, and/or research purposes **OR** presented in scientific presentations or papers. In addition, de-identified information may be submitted in a HIPPA-compliant manner to reasearch databases. It is my desire to opt out of participating in any research studies using my DNA sample (initial here) _______.

Release and Consent

As a courtesy, Capstone Healthcare, LLC makes every reasonable effort to obtain reimbursement for ordered test. I authorize Capstone Healthcare, LLC to release to Medicare, it's carriers, and any insurance carrier or health plan providing benefits to me, any information that may be needed for claim purpose. I am making an assignment of Medicare, Medicaid, and/or insurance company benefits to Capstone Healthcare, LLC. I understand that if my insurance company pays me directly for services rendered by Capstone Healthcare, LLC that I am responsible for forwarding such and all payments directly to Capstone Healthcare, LLC. I also understand and agree that I am responsible for any copayment and/or deductible, as required by my plan. IMPORTANT: I have read and understand the Patient Acknowledgement and Consent as well as the Patient Disclosure on the back of this form, I consent to the testing. I permit a copy to this authorization to be used in lieu of the original.

X ______________________________
Patient Signature Date

X ______________________________
If Patient is a Minor Guardian Signature Date

04.21.20

Name ____________ DOB ____________ Date ____________

Name ____________ DOB ____________ Date ____________

Name ____________ DOB ____________ Date ____________

Name ____________ DOB ____________ Date ____________

ACCOUNT INFORMATION

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Collection Date and Time: ______/______/______ ❑ AM ❑ PM

Collector's Name and Initials ____________________

RESPIRATORY PANEL ORDERED *See panel details on reverse

- ❑ **Respiratory Pathogen Panel[1]***
- ❑ **Respiratory Pathogen Panel w/ COVID 19 (SARS-CoV-2[2])***
- ❑ **COVID 19 (SARS-CoV-2)**

BILLING INFORMATION

❑ Insurance ❑ Medicare ❑ Medicaid
❑ Client Bill ❑ Self Pay ❑ Worker Comp

Insurance Plan ____________________

Policy # ____________________

Policy Phone Number ____________________

MANDITORY ICD10 CODES

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____

____

RESPIRATORY PATHOGEN REQUISITION

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Atlanta, GA 30350

Phone: 844.497.8851 Fax: 470.355.5462
Email: clientservice@capstonehealthcare.com

PATIENT INFORMATION

Attach Copy of the Patient's Face Sheet

Name: ____________________
Last First Middle

Address: ____________________

____
City State Zip Code

Date of Birth: ______/______/______ Sex ❑ Male ❑ Female

Social Security #: __________- __________- __________

Phone #: ____________________

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X ____________________
Patient Signature Date

X ____________________
If Patient is a Minor Guardian Signature Date

***Respiratory Pathogen Panel** Target Organism[1,2]*
Bordetella bronchiseptica / parapertussis / pertussis
Bordetella pertussis
Klebsiella pneumoniae
Haemophilus influenzae
Streptococcus pneumoniae
Legionella pneumophila
Mycoplasma pneumoniae
Staphylococcus aureus
Chlamydophila pneumoniae
Adenovirus
Human Bocavirus
Human Coronavirus 229E
Human Coronavirus HKU1
Human Coronavirus NL63
Human Coronavirus OC43
Human Enterovirus (pan assay)
Human Enterovirus D68
Human Metapneumovirus (hMPV)
Human Parainfluenza virus 1
Human Parainfluenza virus 2
Human Parainfluenza virus 3
Human Parainfluenza virus 4
Human Respiratory Syncytial Virus A (RSVA)
Human Respiratory Syncytial Virus B (RSVB)
Human Rhinovirus 1/2
Human Rhinovirus 2/2
Human herpesvirus 3 (HHV3 Đ Varicella zoster Virus)
Human herpesvirus 4 (HHV4 Đ Epstein-Barr Virus)
Human herpesvirus 5 (HHV3 Đ Cytomegalovirus)
Human herpesvirus 6 (HHV6)
Influenza A
Influenza A/H1-2009
Influenza A/H3
Influenza B
SARS-CoV-2[2]

Patient Acknowledgement and Consent

I consent to submit and voluntarily provide my sample to Capstone Healthcare, LLC/ISPM Labs LLC for testing. I certify that the speciment identified and submitted on this form is my own. I have not adulterated it in any way. I authorize Capstone Healthcare, LLC/ISPM Labs LLC to release the results of this testing to the ordering physician and/or facility.

Patient Disclosure

Please understand that Capstone Healthcare, LLC/ISPM Labs LLC will report the test results to your physician. Capstone Healthcare, LLC/ISPM Labs LLC will bill your insurance or other healthcare coverage plan for this testing. Capstone Healthcare, LLC/ISPM Labs LLC will accept these fees, as determined by your coverage plan, for our services, and you assign all rights to such fee to Capstone Healthcare, LLC/ISPM Labs LLC. Capstone Healthcare, LLC/ISPM Labs LLC will generate a statement to you for any remaining balance. You are responsible for paying Capstone Healthcare, LLC/ISPM Labs LLC for all co-pays, deductibles or non-covered services as dictated by your insurance plan.

Insurance regulations require Capstone Healthcare, LLC/ISPM Labs LLC to seek payment.

For any questions or concerns, please contact Capstone Healthcare, LLC at 844-497-8851. Our address is 8601 Dunwoody Pl. Ste 444, Atlanta, GA 30350.

Physician Acknowledgement and Consent

* I authorize the above ordered laboratory test. If no profile is selected, Capstone Healthcare, LLC/ISPM Labs LLC will test the comprehensive panel (all specialties). Any genetic testing not performed by this laboratory will be forwarded to another accredited laboratory.