BILL PATIENT'S INSURANCE PROVIDER- MUST BE FASTING FOR LABS

PATIENT NAME: _____ DOB: ____/____/____

☑ **BILL INSURANCE PROVIDER** ***(PLEASE COLLECT PATIENT'S INSURANCE INFORMATION)***

SEND COMPLETED RESULTS TO:

PADGETT MEDICAL CENTER

6904 W Linebaugh Ave, Tampa, FL 33625 PH: (813) 888-7710 Fax: 813-908-7711

200 SW 8th Street Suite A Ocala, FL 34471 PH: (352) 369-0104 Fax: 352-369-0107

Dr. Jose Diaz DEA: FD8114566 LIC: ME122262 NPI: 1497792162

_____ _____

DOCTOR SIGNATURE DATE

PLEASE DISREGARD TEST CODES UNLESS USING LAB CORP

☐ MALE	PLEASE DRAW THE FOLLOWING LABS	DX CODES
004283	Luteinizing Hormone (LH), S	R63.5
005009	CBC with diff/platelets	R63.5
010322	PSA	
140103	Testosterone, Free and Total	R53.83
235010	Lipid Panel with LDL/HDL Ratio	
363229	CMP (14), T4, T3, TSH, CBC, FSH, Testosterone Serum,Progesterone, Estron, Estradiol	
010363	IGF-1	
001453	Hemoglobin A1C	
010389	Free T3	
001974	Free T4	
070104	Reverse T3	
004051	Cortisol	
081950	Vitamin D	
001503	Vitamin B12	
004275	Growth Hormone Serum	
004100	DHEA	

Additional tests ordered _____

☐ FEMALE	PLEASE DRAW THE FOLLOWING LABS	DX CODES
001974	Free T4	R63.5
004283	Luteinizing Hormone (LH), S	R63.5
005009	CBC with diff/platelets	R63.5
006676	Thyroid Peroxidase (TPO) Ab	
235010	Lipid Panel with LDL/HDL Ratio	
363229	CMP (14), T4, T3, TSH, CBC, FSH, Testosterone Serum, Progesterone, Estron, Estradiol	
010363	IGF-1	
001453	Hemoglobin A1C	
010389	Free T3	
001974	Free T4	
070104	Reverse T3	
004051	Cortisol	
081950	Vitamin D	
001503	Vitamin B12	
004275	Growth Hormone Serum	
004100	DHEA	
002303	CA125	

Additional tests ordered _____

I hereby authorize the release of medical information related to the services described hereon and authorize payment directly. If using my own insurance, I agree to assume responsibility for payment of charges for laboratory services that are not covered by my health care insurance. Lab Company may not accept this form without patient signature. I am responsible for contacting my insurance provider to verify that the above lab service(s) will be covered.

Patient Signature _____ Date _____