



BILL PATIENT'S INSURANCE PROVIDER

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

Phone: (813) 888-7710

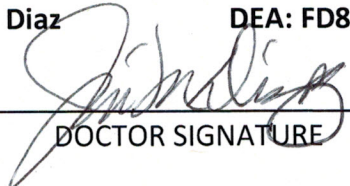
Fax: (813) 908-7711

Dr. Jose Diaz

DEA: FD8114566

LIC: ME122262

NPI: 1497792162



DOCTOR SIGNATURE

DATE

PLEASE DISREGARD TEST CODES UNLESS USING LAB CORP

<input type="checkbox"/> 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	R63.5
010363	IGF-1	
Additional tests ordered _____		

<input type="checkbox"/> 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	R63.5
010363	IGF-1	
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