SHADID
MEDICAL GROUP

Shadid Medical Group Lab Insurance Waiver of Liability

I, _____, agree to have the following testing performed by Dr. S. Christopher Shadid and Shadid Medical Group. Dr. S. Christopher Shadid and Shadid Medical Group have notified me that my insurance carrier may deny payment for the services identified below. If my insurance company denies payment, I agree to be personally and fully responsible for payment.

85025	CBC	$20.00	844031 & 84270	TESTOSTERONE PANEL	$80.00
80053	CMP	$20.00	82670	ESTRADIOL	$40.00
80048	BMP	$20.00	83001	FSH	$20.00
80061	LIPID PANEL	$20.00	84144	PROGESTERONE	$20.00
83036	A1C	$20.00	82627	DHEA-S	$40.00
83063	A1C - IN OFFICE	$25.00	83002	LH	$20.00
84443	TSH	$40.00	82306	VITAMIN D	$40.00
84439	FT4	$20.00	82607	VITAMIN B12	$40.00
84481	FT3	$20.00	82533	CORTISOL	$20.00
86376	TPO AB'S	$20.00	83735	MAGNESIUM	$20.00
83540	IRON	$20.00	86140	CRP	$20.00
83550	IRON SATURATION	$40.00	85651	ESR	$20.00
82728	FERRITIN	$20.00	86430	RHEUMATOID FACTOR	$20.00
82746	FOLATE	$20.00	84550	URIC ACID	$20.00
83525	INSULIN	$20.00	82550	CK (CPK)	$20.00
84153	PSA	$40.00	86703	HIV SCREEN	$20.00
83690	LIPASE	$20.00	86592	RPR (SYPHILIS)	$20.00
82150	AMYLASE	$20.00	86308	MONO SCREEN	$20.00
84703	HCG BLOOD	$20.00	82044	URINE MICROALBUMIN	$20.00
81003	URINE DIPSTICK	$20.00	80300	URINE DRUG SCREEN	$40.00

Payment to Shadid Medical Group will be due within 30 days of denial of service or have a sufficient payment agreement in place.

Patient's Name:_____ Date of Birth: _____/_____/_____

Patient's Signature:_____ Date: _____/_____/_____