Informed and Financial Consent

By signing below you hereby assign all medical and laboratory benefits to Access Genetics to which you are entitled related to the laboratory services performed and authorize and direct your insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Access Genetics for laboratory services rendered to you and/or your dependents regardless of your insurance benefits, if any. You further authorize Access Genetics to obtain any medical records necessary to appeal any testing services performed on your behalf in the event your insurance has denied or partially reimbursed the service. In the event your insurance carrier pays you directly, you agree to notify Access Genetics and forward the payment to them directly. You acknowledge that you are responsible for any amount not covered by insurance. If there is a balance due after your plan benefits have been applied and insurance has paid, you agree to pay that amount within 30 days or may request the application for the Access Genetics PATH Program to be considered for any adjustments for which you may be eligible.

Access Genetics offers different types of clinical tests including genetic tests that analyze for variations in the genetic code. Genetic tests are not diagnostic, but instead are for the purposes of risk assessment. Persons who learn they are at increased risk for any condition based on a genetic test result may never experience the condition. Conversely, a report of a low risk result could still result in a patient experiencing the condition. Genetic testing that is ordered may include only selected genes and not all potentially applicable genes. Our genetic tests are intended to help you and your healthcare provider plan and follow a course of treatment using your genetic information as a resource.

Genetic testing can be complex and we want you to be well informed prior to making a decision to be tested. Your decision to be tested is voluntary and Access Genetics will make qualified counselors available to you to answer any questions. Information about all our tests is available either in our test directory or at www.access-genetics.com. You may also call us at 855.202.6109.

Your specimen will be sent to the Access Genetics Clinical Laboratory. DNA will be isolated and genetic tests will be performed. You agree to allow Access Genetics to perform the ordered tests as well as additional tests that are not being reported. The results and the interpretation of the ordered tests will be reported to the ordering healthcare provider. Your results should be evaluated in the context of personal and family history, the results of a physical examination, the results of other laboratory tests, and the clinical expertise of your healthcare provider. You agree that Access Genetics has no responsibility to notify you of risks revealed by any genetic tests we may perform that were not ordered.

Access Genetics protects the privacy of personal information and test results and is in full compliance with the regulations of the Health Insurance Portability and Accountability Act (HIPAA). We will only release your test results to your healthcare provider or designee, or to another healthcare provider as directed by you in writing, or as otherwise required by federal or state laws. By signing this consent you agree to allow Access Genetics to archive your specimen and derivative analysis and data for an indefinite time period. You also agree that Access Genetics may use your specimen, clinical information, and test results, whether ordered or not, for research purposes, educational studies, commercial purposes and/or publication as long as all personal information has been de-identified. Any derivative products, tests or discoveries with commercial value are hereby assigned to Access Genetics.

By signing this consent form you acknowledge that you are at least 18 years old, that you have the capacity to consent, and that you do consent to the testing described and other provisions above, and have had adequate explanation and consultation through your healthcare provider.

Patient Printed Name _____

Patient Signature _____ Signature Date _____

Guardian Signature (if required) _____ Signature Date _____