Henry Ford Health System
CENTER FOR PRECISION DIAGNOSTICS

Pathology and Laboratory Medicine
Clinic Building, K6, Core Lab, E-655
2799 W. Grand Blvd. Detroit, MI 48202
855.916.4DNA (4362)
hfcpd@hfhs.org

MOLECULAR AND CYTOGENOMICS FINANCIAL RESPONSIBILITY AGREEMENT

Patient Information

Name: _____ **Gender:** M F DOB: MM / DD / YYYY **MRN:** _____

Date of Service: MM / DD / YYYY ❑ Self- Pay ❑ Retail

Election for Self-Pay or Retail Services and Patient Acknowledgement of Financial Responsibility and Agreement

- I am choosing to waive the use of my health insurance coverage for the testing listed below. No health insurance claim form will be sent to my health insurance company.
- Retail services cannot be reimbursed at any time by my respective insurance carrier(s), nor applied toward my deductible.
- I will receive an invoice and will be held financially responsible for charges associated with the retail services rendered by Henry Ford Center for Precision Diagnostics.
- I have read the above and have had the opportunity to ask any questions about this form. Any questions I may have had about this form have been answered to my satisfaction.

Test(s) ordered: _____ Estimated cost: _____

Test(s) ordered: _____ Estimated cost: _____

Test(s) ordered: _____ Estimated cost: _____

Test(s) ordered: _____ Estimated cost: _____

My signature below acknowledges the receipt and complete understanding of the Henry Ford Center for Precision Diagnostics Election for Self-Pay or Retail Services and Patient Acknowledgement of Financial Responsibility and Agreement

_____ _____

Signature of Patient or Authorized Designee Date