2026 Hamilton Memorial Hospital Fall Lab Fair Registration

Patient Name:	**Birth Date:**
Address: **Street** **City, State Zip Code**	**Gender:** [ ] Male [ ] Female
Telephone:	**Age**
Social Security Number: ___ ___ ___ - ___ ___ - ___ ___ ___ ___	
Email Address:	

Please select the health screenings you would like to have completed:

Screening Packages:

[ ] **Health Screen** **$50.00**

- Glucose, cholesterol/lipid panel, BUN, Creat, Lytes, Calcium, Total Protein, Albumin, AST, Alk Phosphate, Total Bili, ALT, CBC, Hgb, Hct, GFR, and TSH

[ ] **Health Screen Plus PSA** *(Men only)* **$70.00**

- Includes same testing as the $50 Health Screen Profile with the addition of PSA screening for prostate cancer in men.

Additional Screenings Available:

[ ] **Vitamin D** **$35.00**

[ ] **A 1C Screening** **$25.00**

- Diabetic 90-day blood sugar average check

Hamilton Memorial Hospital District

Advance Beneficiary Notice and Release of Information:

Because your physician did not order these specific laboratory tests, they are not covered under Medicare or Private Insurance. Because of this, it cannot be turned in to any agency for payment coverage. By signing below, you are agreeing to the above statements and agree that you will not turn these in to your insurance carrier.

You may list your personal care physician as indicated below so that a copy of your lab results can be faxed to their office.

To receive a copy of your own results, an Authorization for Release of Information has to be signed. This is accomplished by signing below, and selecting your method of receipt.

I hereby authorize to release to my primary care physician and myself the following information: Wellness Health Screen and Laboratory Results. This authorization expires 120 days from the date it is signed.

I understand this screening is not performed by a physician and is not intended to be diagnostic of any medical condition.

I further understand it is my sole responsibility to follow up with my/a physician regarding any screening results or other information I obtain from my participation in the Fall Health Fair Screenings.

I agree to release and hold harmless Hamilton Memorial Hospital and Family Clinics, including any of its employees or independent staff physicians, from any and all claims, of any nature whatsoever, related to my participation in the Fall Health Fair Lab Screenings.

Signature: _____ Date: _____

My HMHD Primary Care Provider (PCP) is:

Please Circle One *(results can only be sent to one provider)*

B. Sloan, MD
M. Warren, NP
L. DeVous, FNP
H. Johnson, AGACNP/FNP
J. Robinson, FNP
J. Jacobs, FNP
K. Adams, NP

My Provider is not at HMHD, I would like my results sent to:

Name: _____

Address: _____

I understand that I will not receive a physically printed copy of my results. Results will be available via MyChart online, or by going to the Health Information Office and requesting the results to be printed. (Results will be available for printing one week after testing date) _____
Initial

TOTAL COST:

[ ] Cash
[ ] Check
(Make Payable to Hamilton Memorial Hospital)