ClarityLabs
Testing for Better Health

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CLIA # 31D2140149

Clinic Information

Acct #251
Saving Lives Center Family Clinic and Urgent Care
188 Thomas Johnson Drive, Suite 102
Frederick, MD 217023
[ ] Osidele, Oluwakemi

Patient Information

Patient Name (Last, First)

Sex: M / F

DOB (MM/DD/YYYY) / /

Social Security #:

Phone #

Address (Street, City, State, Zip code)

Insurance Information

Attach Copy of Insurance Card(s) & Driver's License

Primary: ☐ Medicare ☐ Medicaid ☐ Commercial ☐ Self-Pay

INS. Provider (Name):

INS. Address:

Policy #

Policy Holder Name: DOB (MM/DD/YYYY):

Relation to Patient: ☐ Self ☐ Spouse ☐ Parent

Providers

Authorized Signature: *Date:*

X

Physician Medical Necessity Notice

Physicians and other authorized persons are required to only order medically necessary tests supported by an ICD-10 diagnosis from the patient's medical record.

Patient Signature

X

I authorize Solaris Diagnostics to analyze the specimen provided by me and report the results of such analysis to the ordering Physician in conformance with his/her order. (Further explanation on back)

Specimen Processor

Collector's Name:

Collection Date: / / Time: : ☐ AM ☐ PM

Specimen Information

☐ E-swab ☐ Cervical Brush ☐ Fecal Swab
☐ Serum ☐ Urine ☐ Other Site:

Diagnosis Code(s) (Req'd)

Performed w/ E-Swab or Cervical Brush

Women's Health

- ☐ **Bacterial Vaginosis**
  - ☐ Mobiluncus curtisii & mulieris
  - ☐ Megasphaera type 1&2
  - ☐ Ureaplasma urealyticum
  - ☐ Prevotella bivia
  - ☐ Gardnerella vaginalis
  - ☐ BVAB2
  - ☐ Atopobium vaginae
  - ☐ Mycoplasma hominis
  - ☐ L. crispatus/ gasseri/ iners/ jensenii
- ☐ **Aerobic Vaginitis**
  - ☐ Staphylococcus aureus w/ MRSA
  - ☐ Streptococcus agalactiae (GBS)
  - ☐ Escherichia coli
  - ☐ Enterococcus faecalis
- ☐ **Candidiasis Panel**
- ☐ **STI Panel**
  - ☐ Trichomonas Vaginalis
  - ☐ Chlamydia trachomatis
  - ☐ Neisseria gonorrhoeae
  - ☐ Mycoplasma genitalium
  - ☐ Mycoplasma hominis
  - ☐ Ureaplasma urealyticum
- ☐ **Genital Ulcer Panel**
  - ☐ Herpes simplex 1 & 2
  - ☐ Haemophilus ducreyi
  - ☐ Treponema pallidum

35th Week Strep B
☐ Streptococcus agalactiae (GBS)

HPV
☐ HPV High Risk Testing

Performed w/ Urine C&S Tube

Uro Panel

- ☐ **Urine STI Panel**
  - ☐ Mycoplasma hominis
  - ☐ Ureaplasma urealyticum
  - ☐ Mycoplasma genitalium
  - ☐ **Leukorrhea Panel**
    - ☐ Trichomonas Vaginalis
    - ☐ Neisseria gonorrhoeae
    - ☐ Chlamydia trachomatis
- ☐ **UTI ID Panel**
  - ☐ E. Coli
  - ☐ Staphylococcus aureus
  - ☐ Staphylococcus Saprophyticus
  - ☐ Enterococcus faecalis
  - ☐ Ureaplasma urealyticum
  - ☐ Mycoplasma hominis
  - ☐ Candida Species
  - ☐ Proteus Mirabilis
  - ☐ Klebsiella Pneumoniae
  - ☐ Morganella morganii
  - ☐ Serratia Marcescens
  - ☐ Klebsiella oxytoca
  - ☐ Enterobacter cloacae
  - ☐ Providencia Stuartii
  - ☐ Pseudomonas Aeruginosa
  - ☐ Streptococcus Agalactiae
  - ☐ "Resistance Markers"
  - ☐ "Antibiotic Sensitivity"

Urinalysis Reflex to UTI/Sensitivity
☐ UA, UTI ID & Sensitivity

Performed w/ E-Swab

Respiratory

- ☐ **In Office Flu Test Performed**
- ☐ **Viral Targets**
  - ☐ Coronavirus HKU1
  - ☐ Coronavirus NL63
  - ☐ Coronavirus 229E
  - ☐ Coronavirus OC43
  - ☐ Human Metapneumovirus A/B
  - ☐ Human Rhinovirus
  - ☐ Human Enterovirus
  - ☐ Influenza A, B, C
  - ☐ Influenza A/H1-2009
  - ☐ Parainfluenza Virus 1, 2, 3, 4
  - ☐ Respiratory Syncytial Virus A/B
  - ☐ Adenovirus
  - ☐ Bocavirus
  - ☐ Parechovirus
- ☐ **Bacterial Targets**
  - ☐ *Mycoplasma pneumoniae*
  - ☐ Chlamydia pneumoniae
  - ☐ Streptococcus pneumoniae
  - ☐ Klebsiella pneumoniae
  - ☐ Legionella pneumophila
  - ☐ Legionella longbeachae
  - ☐ Haemophilus influenzae B
  - ☐ Salmonella Spp
  - ☐ Moraxella catarrhalis
  - ☐ Bordetella Spp
  - ☐ Haemophilus influenzae
  - ☐ **MRSA**
    - ☐ Staphylococcus aureus
    - ☐ MRSA
- ☐ **Fungal Targets**
  - ☐ Pneumocystis Jirovecii (F)

Strep A (PCR)
☐ Streptococcus pyogenes

Performed w/ Fecal Swab

Gastrointestinal

- ☐ **Bacterial Gastroenteritis**
  - ☐ Campylobacter spp.
  - ☐ Clostridium difficile
  - ☐ Verotoxin positive E. coli
  - ☐ Enteroinvasive E. coli
  - ☐ Enteropathogenic E. coli
  - ☐ Enteroaggregative E. coli
  - ☐ Enterotoxigenic E. coli
  - ☐ Enterohemorrhagic E. coli
  - ☐ Salmonella spp.
  - ☐ Shigella spp.
  - ☐ Yersinia enterocolitica
- ☐ **Stool Parasites**
  - ☐ *Entamoeba histolytica*
  - ☐ Cryptosporidium spp.
  - ☐ Giardia lamblia
- ☐ **Viral Gastroenteritis**
  - ☐ Norovirus G1, G2
  - ☐ Adenovirus
  - ☐ Astrovirus
  - ☐ Rotavirus
  - ☐ Sapovirus

Helicobacter pylori
☐ Helicobacter pylori

Occult Blood, Fecal
☐ Occult Blood, Fecal

Additional Testing

Performed w/ E-Swab

Wound

- ☐ Acinetobacter baumannii
- ☐ Bacteroides spp.
- ☐ Citrobacter freundii
- ☐ Enterobacter aerogenes
- ☐ Enterobacter cloacae
- ☐ Enterococcus faecalis
- ☐ Enterococcus faecium
- ☐ Escherichia coli
- ☐ Klebsiella Oxytoca
- ☐ Klebsiella Pneumoniae
- ☐ Morganella morganii
- ☐ Proteus mirabilis
- ☐ Proteus vulgaris
- ☐ Pseudomonas aeruginosa
- ☐ Staphylococcus aureus
- ☐ Streptococcus pyogenes
- ☐ Clostridium novyi
- ☐ Clostridium septicum
- ☐ Clostridium perfringens
- ☐ Kingella kingae
- ☐ "Resistance Markers"
- ☐ "Antibiotic Sensitivity"

Performed w/ Nail Clipping

Nail Fungus

- ☐ Acremonium strictum
- ☐ Alternaria
- ☐ Aspergillus niger
- ☐ Aspergillus terreus
- ☐ Epidermophyton floccosum
- ☐ Fusarium solani
- ☐ Microsporum audouinii
- ☐ Microsporum canis
- ☐ Trichophyton interdigitale
- ☐ Trichophyton rubrum
- ☐ Neofusicoccum mangiferae
- ☐ Candida Spp

Continued Patient Authorization Information:

I also authorize my Physician and his/her staff to disclose any protected health information ("PHI") needed to determine my benefits for laboratory analysis services to Lab for the purposes of obtaining payment for providing laboratory services to Patient. The Lab and receiving health information under this authorization will not receive direct or indirect remuneration in exchange for disclosing the health information. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this form. I understand that I have the right to refuse to sign this authorization. I understand that, as set forth in the notice of privacy practices, I have the right to revoke this authorization, in writing, at any time except to the extent that the Physician/Lab which is to make the disclosure has already taken action in reliance on it. I understand that PHI used or disclosed pursuant to this authorization may be re-disclosed by the recipient and its confidentiality may no longer be protected by federal or state law. If not previously revoked, this consent will terminate upon that date which is one year after Patient's last encounter for which Physician ordered laboratory analysis from Lab for Patient. A disclosure may not be made on the basis of a consent which:

(1) has expired;

(2) on its face substantially fails to conform to any of the requirements set forth in 42 C.F.R. § 2.31(a);

(3) is known to have been revoked; or

(4) is known, or through a reasonable effort could be known, by the person holding the records to be materially false.

Additionally, I authorize payments from insurance companies, or other third-party payers to be made to Lab for the laboratory services it has provided. I understand that I am responsible for the payment of any deductibles or co-insurance charges, if applicable. I understand that Lab may be an out-of-network provider with my insurer or third-party payer. If my insurance company, or other third-party payer makes payment directly to me, I will endorse said check and forward it to Lab within 30 calendar days of its receipt. I understand that failure to do so may result in my account being forwarded to collections and reported to a credit bureau. If I am a self-pay patient, I accept full financial responsibility for any payment due Lab for its laboratory services provided on my behalf.

This information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

I, the undersigned acknowledge that this specimen was provided voluntarily for analysis and I authorize Solaris Diagnostics to administer results on my behalf and to bill my health insurance provider for services provided to me. I hereby allow the release of any personal or medical information as needed to process this claim and I acknowledge and understand payment(s) for services may be made on my behalf by my health insurance provider to Solaris Diagnostics. I may be responsible for co-pays and deductibles not covered by my health insurance provider.