GENETIC ASSAYS
A Molecular Diagnostics Laboratory

Self-Pay Authorization Form*

***Health Care Provider: Once signed by the patient, attach this form to the lab request form, so as not to delay performance of the test(s) ordered.**

Patient Name: _____ **DOB:** ____/____/____

Please check the box of the test(s) you choose to be performed from the following menu:

Test Name	Self-Pay Price
☐ Respiratory Panel with COVID-19	$199.00
☐ Diarrhea Panel	$199.00
☐ Bacterial Vaginosis Panel	$189.00
☐ HSV-1&2	$99.00

Self-Pay Authorization: I understand that my doctor has ordered this testing to be performed by Genetic Assays, Inc. I authorize Genetic Assays, Inc. to bill my credit card for the test(s) performed at the price listed, as indicated by my signature below.

Signature: _____ **Date:** ____/____/____

Name on Credit or Debit Card: _____

Credit Card Number: _____

Expiration Date: _____/_____

CVV or CVC (3 digits on back of card): _____

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