



4350 Oakes Road STE 513  
 Davie, FL 33314  
 Laboratory Director: Jo Ann Wilson, Ph.D.  
 Phone: 954-541-3705 CLIA # 10D2079014

**Clinic Information**

**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 ASAP Lab 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

Performed w/ Urine C&S Tube

Performed w/ E-swab

Performed w/ E-swab or clipping

**Women's Health**

**Women's Health Complete**

- Bacterial Vaginosis
  - Mobiluncus curtisii & mulieris
  - Megaspheera 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  
(albicans, tropicalis, glabrata, krusei, lusitanae, parapsilosis)
- 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)

**Pap Smear**

Source:  Vaginal  Cervix

Request:  Routine  Diagnostic

Reflex HPV Testing

**URO**

**Complete URO Panel**

- UTI Panel (ABR & Sensitivity)**
  - Enterococcus faecalis
  - Escherichia coli
  - Klebsiella pneumoniae
  - Proteus mirabilis
  - Staph. saprophyticus
  - Candida Species
  - Enterobacter cloacae
  - Klebsiella oxytoca
  - Morganella morganii
  - Mycoplasma hominis
  - Providencia stuartii
  - Pseudomonas aeruginosa
  - Serratia marcescens
  - Staphylococcus aureus
  - Streptococcus agalactiae
  - Ureaplasma urealyticum
- Urine STI Panel**
  - Mycoplasma hominis
  - Ureaplasma urealyticum
  - Mycoplasma genitalium
  - Leukorrhea Panel**
    - Trichomonas Vaginalis
    - Neisseria gonorrhoeae
    - Chlamydia trachomatis

**Respiratory**

**Complete Respiratory Panel**

- Viral Targets**
  - Influenza Panel
    - Influenza (A, H1-2009, H3)
    - Influenza B
    - Influenza C
    - Parainfluenza (1, 2, 3, 4)
  - Common Cold Panel**
    - Adenovirus
    - Human Bocavirus
    - Human Coronavirus (HKU1/NL63/229E/OC93)
    - Human Enterovirus
    - Human Rhinovirus
    - Human Parechovirus
  - Respiratory Syncytial Virus A/B
  - Human Metapneumovirus A/B
  - SARS (Severe Acute Resp Syndrome)
  - MERS (Middle East Resp Syndrome)
- Bacterial Targets**
  - Pneumonia Panel**
    - Mycoplasma pneumoniae
    - Chlamydia pneumoniae
    - Streptococcus pneumoniae
    - Klebsiella pneumoniae
    - Haemophilus influenzae/Type B
    - Legionella pneumophila/longbeachae
  - Moraxella catarrhalis
  - Coxiella burnetii
  - Whooping Cough
    - Bordetella pertusis
    - Bordetella parapertusis
    - Bordetella holmesii
  - MRSA
    - S.aureus
    - MRSA
- Fungal Targets**
  - Pneumocystis Jirovecii

**Wound / Nail**

**Complete Wound / Nail Panel**

- Bacterial (ABR & Sensitivity)**
  - 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
- Fungal Targets**
  - Acremonium strictum
  - Alternaria
  - Aspergillus niger
  - Aspergillus terreus
  - Epider. floccosum
  - Fusarium solani
  - Microsporum audouinii
  - Microsporum canis
  - Trichophyton interdigitale
  - Trichophyton rubrum
  - Neofusi. mangiferae
  - Candida Spp

Additional Testing

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 ASAP Lab 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 ASAP Lab. I may be responsible for co-pays and deductibles not covered by my health insurance provider.