Mitchell County Health Department
310 W. 8th St Beloit, KS 67420
785-738-5175

2024 Mitchell County Health Department Health Fair

Test #_____

CIRCLE REQUESTED TEST (S)

Health Fair Panel (CBC, Lipid Panel, Comprehensive Panel) **$40.00**	**Health Fair A1C** **(For Diabetics Only)** **$20.00**
Health Fair TSH **$25.00**	**Health Fair PSA** **(For Men)** **$25.00**

THESE TESTS ARE NOT BILLABLE TO INSURANCE

There is a $10 draw fee per person, not per test

Fasting: Nothing to eat or drink but black coffee, tea or plain water YES or NO

LAST NAME (please print): _____ FIRST NAME: _____

MAILING ADDRESS: _____

CITY: _____ STATE:_____ ZIP: _____

BIRTH DATE: _____ PHONE NUMBER: _____

PRIMARY DOCTOR: _____ EMAIL: _____

PARTICIPANT CONSENT AND RELEASE STATEMENT

I understand that the Mitchell County Health Department/Mitchell County Hospital Health System disclaims any liability for any costs, claims, injuries, actions or damages suffered by an individual, no matter what their relationship, as the result of participation in the Mitchell County Health Fair Testing/Mitchell County Hospital Health System. Participation in the Mitchell County Health Fair Testing is strictly voluntary, and any injuries suffered in conjunction with such participation shall not be subject to reimbursement under any applicable law. I agree to release the Mitchell County Health Department/Mitchell County Hospital Health System and any other person associated with these tests from any liability whatsoever in connection with testing procedures, or any other aspect of the screening.

I understand that the results of these tests will be mailed directly to me.

I understand that these tests are for screening purposes only, and the results are preliminary and should in no way be considered conclusive. Moreover, by providing these results, the Mitchell County Health Department/Mitchell County Hospital Health System is not giving medical advice. **For a better understanding of the results of these tests, for more conclusive measurements, and for any additional medical advice and treatment, I understand that it is my responsibility to contact my own personal physician.**

I acknowledge that I have received or been offered a copy of the Mitchell County Health Department's Notice of Privacy Practices with the effective date of 06/19/2023.

Any minor under 18 years of age must have his or her legal guardian sign this consent.

The tests are available for a minimal fee to cover expenses and no receipt will be given.

_____ _____

Signature Required – Relationship to client **Date**

OFFICE USE ONLY:
Total amount paid: _____ Cash: _____ Check: _____ Check Number: _____