PRE-REGISTER

DUE BY NOON ON 10/11/24 FOR EXPEDITED BLOOD DRAWS THE DAY OF THE HEALTH FAIR

Turn forms and payment in at Logan County Hospital, New Frontiers, Urgent Care or Logan County Health Department.

LOGAN COUNTY HEALTH FAIR

October 19th, 2024

Oakley, KS 67748

785-671-4502

www.logancountyhealth.com

NAME________________________________ BIRTH DATE __________________

ADDRESS_____________________________ GENDER Female Male

CITY________________ST_______ZIP CODE________ PHONE_____________________

WELLNESS PROFILE	_______	$40	(CMP, CBC, Lipid, A1C) G,G, P,P
THYROID PANEL	_______	$40	(TSH, FT4, FT3) G
ANEMIA PANEL	_______	$50	(Iron, Ferritin, Vit. B12, Folate) G
VITAMIN D	_______	$50	G
C-REACTIVE PROTEIN	_______	$50	G
TESTOSTERONE	_______	$30	R
PSA	_______	$30	R

TOTAL $_________ CASH_____ CHECK#____________ (Payable to LCHD)

A copy of the screening results will be available at the health department for you to pick up. It will be your responsibility to discuss the results with your medical provider and to follow-up for any diagnosis or treatment required due to abnormal results.

Screening procedures used are not the same as an examination by your medical provider. Screenings are meant to designate areas that may need further evaluation if the results vary from normal. I understand that no doctor-patient relationship is agreed to and no duty is owed to me. I further agree that the screening tests were requested by me and not ordered by any medical provider nor meant to prevent, detect, or assist in the continued treatment of any medical problem.

I hereby release any and/or all sponsors and participants including: Logan County Hospital, Logan County Health Department, and any participating Medical Provider from any and/or all liability from any incident, act of omission, or commission which arises during any portion of the lab screenings.

Your confidentiality is preserved and all HIPAA regulations and rules apply. By signing this form you are in agreement with those terms. If you would like to receive a copy of the HIPAA Notice of Privacy Practices, copies are available from the staff assisting you.

SIGNATURE____ DATE________________

Date_______________ Time___________________ Phlebotomist____________________________