APPLIED INGENUITY DIAGNOSTICS

Form Version 1.0

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PATIENT INFORMATION

First Name

Last Name Middle Name

Street Address/ Apt. #

City State Zip

Date of Birth ☐ Male ☐ Female

Ethnicity ☐ Native American ☐ Asian ☐ Black/ African-American ☐ White/ Caucasian ☐ Hispanic/ Latino ☐ Other

Phone #

Email

Medical Record #

PROVIDER INFORMATION

Client/ Facility

Street Address/ Suite #

City State Zip

Ordering Provider

NPI #

Fax Email

Specimen Information

Collection Date Time ☐ AM ☐ PM

Hours since last meal _____ : _____ ☐ Fasting ☐ Non-Fasting

Specimen Types ☐ Blood ☐ Urine ☐ Other _____

Collection Site ☐ On–Site ☐ Mobile Phlebotomy Unit ☐ Third–Party Testing

Insurance Billing

Patient Relation to Policy Holder ☐ Self ☐ Spouse ☐ Child

Name of Policy Holder

Policy Holder Date of Birth

Policy #

Insurance Type: ☐ Commercial ☐ Medicare ☐ Medicaid

Insurance Company Name

Institutional Billing

Facility Name

PO #

CC Type: ☐ Visa ☐ Mastercard ☐ AMEX ☐ Discover

CC #

CVV Exp Date

Patient Billing

Name

CC #

CC Type: ☐ Visa ☐ Mastercard ☐ AMEX ☐ Discover

CC #

Exp Date

☐ Respiratory Panel

SARS-COV2 (COVID19), Influenza A, Influenza B, Adenovirus, Rhinovirus, Enterovirus

☐ MRSA

Methicilin Resistance, Coagulase Negative Staphylococcus, Staphylococcus

☐ Drug & Alcohol Test Panel

Amphetamines, Alcohol, Barbiturates, Benzodiazepines, Buprenorphine, Cannabinoid, Cocaine, Ecstasy, Methadone, Norfentanyl, Opiates, Oxycodone, Phencyclidine, Urine Creatinine

☐ Full Respiratory Panel

Bordetella Pertussis, Chlamydia Pneumoniae, Mycoplasma Pneumoniae, Streptococcus Pneumoniae, Adenovirus, Influenza A, Influenza B, HMPV, Bocavirus 1-4, Enterovirus, Rhinovirus, Parainfluenza 1, 2, 3, RSV A, RSV B, SARS-COV2 (COVID19)

☐ Wound Culture

35 Bacterial + Fungal and Protozoa Pathogens

Staphylococcus aureus, MRSA, Staphylococcus hominis, Staphylococcus epidermidis, Staphylococcus haemolyticus, Streptococcus pneumoniae, Streptococcus pyogenes, Streptococcus agalactiae, Enterococcus faecalis, Enterococcus faecium, Actinobaculum schaalii, Listeria monocytogenes, Gardnerella vaginalis, Atopobium vaginae, Serratia marcescens, Salmonella sp., Shigella sp., Citrobacter sp., Enterobacter sp., Acinetobacter baumannii, Stenotrophomonas maltophilia, Klebsiella pneumoniae , Klebsiella oxytoca, Achromobacter xylosoxidans, Proteus mirabilis, Pseudomonas aeruginosa, Burkholderia cepacia, Neisseria meningitidis, Haemophilus influenzae, Bordetella pertussis, Lactobacillus crispatus, Lactobacillus iners , Megasphaera sp., Ureaplasma parvum, Ureaplasma urealyctium, Candida dubliniensis, Candida parapsilosis, Candida krusei, Candida glabrata, Candida tropicalis, Candida albicans, Aspergillus fumigatus, Aspergillus flavus, Aspergillus nidulans, Aspergillus niger, Mucor sp., Coccidioides sp., Trichosporon sp., Entamoeba histolytica

Medical Necessity

☐ Fever
☐ Cough
☐ Shortness of Breath of Difficulty Breathing
☐ Sore Throat
☐ Loss of Taste or Smell
☐ Chills
☐ Muscle Aches
☐ Nausea, Diarrhea, Vomiting
☐ Have you tested positive for COVID19 in the past
☐ Are you presumptive COVID19 positive based on symptoms

Other Information

ICD-10 Codes

☐ A49.02 – MRSA
☐ A55 – Chlamydial lymphogranuloma (venereum)
☐ A56.00 – Chlamydial infection of lower genitourinary tract, unspecified
☐ A56.8 – Sexually transmitted chlamydial infection of other sites
☐ A64 – Unspecified sexually transmitted disease
☐ B10.89 – Other human herpes virus infection
☐ B97.29 – Other Coronavirus
☐ J06.9 – Upper resp Infection
☐ J12.89 – Other Viral Pneumonia
☐ J22 – Lower resp Infection
☐ J98.8 – Infection, Respiratory
☐ R05 – Cough
☐ R09.3 – Abnormal Sputum
☐ R50.9 – Fever, Unspecified
☐ Z20.818 – Actual Exp to CVD-19
☐ Z03.818 – Possible Exp to CVD-19
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____
☐ _____

I hereby consent to Applied Ingenuity Diagnostics, LLC performing the designated test(s) on the DNA sample provided by me. My signature below constitutes my acknowledgment that I have been informed, by a physician or other licensed practitioner, of the benefits and limitations of this testing. I also consent to Applied Ingenuity Diagnostics, LLC - or its reference lab - to providing de-identified information for a statistical nature to accrediting agencies and Applied Ingenuity Diagnostics, LLC reserves the right to use such anonymous information in compliance with applicable regulations. Assignment of Benefits: I hereby authorize Applied Ingenuity Diagnostics, LLC or its affiliate to bill my insurance company and receive payment from them on my behalf. I acknowledge, however, that I am responsible for payment of my account and any and all charges associated with its collection. I hereby authorize my insurance company to pay the company directly for services rendered. Appeal Authorization: In the event of an underpayment or denial by my insurance carrier, I hereby authorize the company or their designee, to appeal my health plan on my behalf to provide the actions and information necessary to overturn the denial or receive reimbursement for the underpaid claim including any rights to penalties and attorney's fees provided under LRS §22:1821(A) and other state laws as may be applicable. This authorization shall remain valid until the charges for the orders on this form are paid in full.

Patient Signature: Date:

☐ I consent to the ANONYMOUS use of my sample for research purposes: Note: if left blank, consent is interpreted as NO.

☐ I consent to communication via text or email.

Ordering Provider's Signature: Date: