FORM MUST BE FILLED IN WITH YOUR INFORMATION BEFORE ARRIVING AT THE FACILITY

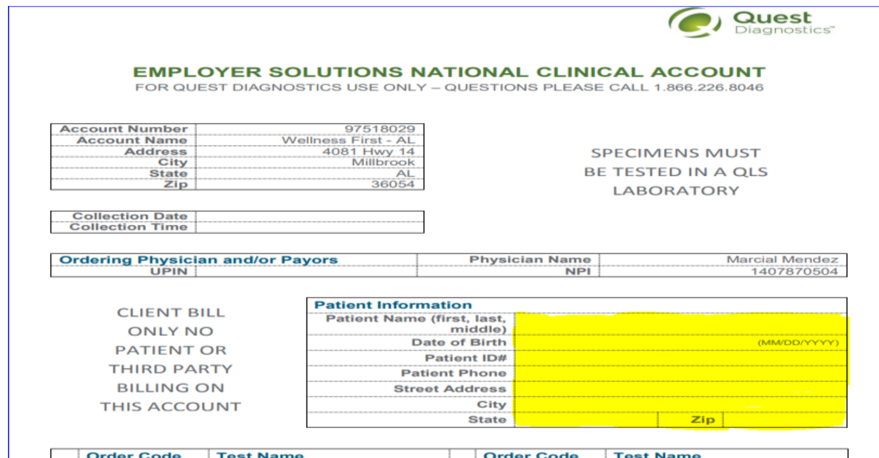
Example/Explanation of Quest Form: (2 part form)

Top Portion: THE ACCOUNT NAME IS WELLNESS FIRST NOT AMGH.

EMPLOYEE: Complete all information in the **highlighted** fields. This information will be used to mail your results to you.

PLEASE PRINT CLEARLY.

Patient ID #: Enter the **last 4 digits of your social security #**.



Quest Diagnostics

EMPLOYER SOLUTIONS NATIONAL CLINICAL ACCOUNT

FOR QUEST DIAGNOSTICS USE ONLY – QUESTIONS PLEASE CALL 1.866.226.8046

Account Number	97518029
Account Name	Wellness First - AL
Address	4081 Hwy 14
City	Millbrook
State	AL
Zip	36054

SPECIMENS MUST BE TESTED IN A QLS LABORATORY

Collection Date	
Collection Time	

Ordering Physician and/or Payors		Physician Name	Marcial Mendez
UPIN		NPI	1407870504

CLIENT BILL ONLY NO PATIENT OR THIRD PARTY BILLING ON THIS ACCOUNT

Patient Information			
Patient Name (first, last, middle)			
Date of Birth	(MM/DD/YYYY)		
Patient ID#			
Patient Phone			
Street Address			
City			
State		Zip	

	Order Code	Test Name		Order Code	Test Name

Please PRINT YOUR NAME, Sign and Date the consent form.

Patient Authorization for Use and Disclosure of Protected Health Information

I authorize my health care providers, Wellness First and University Services staff and laboratories that run medical tests for me to use and disclose certain protected health information about me.

The protected health information will be used or disclosed for the sole purpose of complying with state and federal laws. These laws authorize a review and approve laboratory requisitions and review laboratory results.

I authorization my protected health information and laboratory test results to be mailed through the United States Postal Service in order for me, the patient , to receive results to allow me to make informed decisions about my health care.

I understand that I have to receive a copy of this authorization. I understand that I will not be able to receive laboratory testing unless I sign this authorization. I understand I have the right to refuse to sign this authorization. I understand that by signing this authorization I may not be continued to be protected under the HIPPA Privacy Rule. This authorization will expire one year after the date of this authorization.

I understand that this authorization is for my consent to participate in the AMGH Wellness performed by Wellness First and the parties listed above. I have received a copy of this authorization and consent to its terms and representations.

Name:

Signature:

Date:

QUESTIONS: WELLNESS FIRST @ 205-842-1336

Outside Alabama

Quest Personnel: If any questions, please contact
Andrea.P.Pogue@questdiagnostics.com
210.439.4613

EMPLOYER SOLUTIONS NATIONAL CLINICAL ACCOUNT

FOR QUEST DIAGNOSTICS USE ONLY – QUESTIONS PLEASE CALL 1.866.226.8046

Account Number	97518030
Account Name	Wellness First – US
Address	4081 Hwy 14
City	Millbrook
State	AL
Zip	36054

SPECIMENS MUST BE TESTED IN A QLS LABORATORY

Collection Date	
Collection Time	

Ordering Physician and/or Payors		**Physician Name**	Chandra Matadeen-Ali
UPIN		**NPI**	1811197619

PATIENT INFORMATION SECTION MUST BE COMPLETED PRIOR TO GOING TO LAB

CLIENT BILL ONLY NO PATIENT OR THIRD PARTY BILLING ON THIS ACCOUNT

Patient Information			
Patient Name (first, last, middle)			
Date of Birth	(MM/DD/YYYY)		
Patient ID#			
Patient Phone			
Street Address			
City			
State			

	Order Code	**Test Name**		**Order Code**	**Test Name**
x	483	Glucose	x	91695	Weight
x	7600	Lipid Panel	x	19689	Height
			x	91696	Blood Pressure
			x	16349	Waist Circumference

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Name:

Signature:

Date:

This signed and dated authorization form must accompany your physician form and lab forms