Multiphasic Blood Analysis

Friday, October 18, 2019

7AM – 10AM

Mon Health SM Medical Center

Friday October 18, 2019

☐ **Westover Rotary**

City Neon (Chaplin Road-
across from Mylan Park)

No walk-ins will be taken at this site.

The cost for the preregistered multiphasic blood analysis is $35. A Prostate-Specific Antigen (PSA) blood test (for men only), a Thyroid Stimulating Hormone (TSH) screening and the Glucose A1-C are available for an additional cost of $15 each. Vitamin D test is available for $20. **No registrations will be taken over the phone. Printable forms are available on our web page at www.monhealth.com. A confirmation letter will be sent out after payment and registration are received. Please call (304) 285-2730 if you have any questions.**

Make checks payable to *Mon Health* and mail to: **Mon Health**
P.O. Box 1615
Morgantown, WV 26507

Please mark your 1st & 2nd choice: [ ] 7AM – 8AM [ ] 8AM – 9AM [ ] 9AM – 10AM

Name_____ Date of Birth (required) ____/____/____

Address_____City_____State_____Zip_____

Email _____

Social Security Number _____ Phone ( )_____ Sex: M / F

Please Check: [ ] Multiphasic $35 [ ] PSA (Men Only) $15 [ ] Thyroid $15 [ ] Glucose A1-C $15 [ ] Vitamin D $20

Amount Enclosed $_____

Informed Consent (Please read and sign): I allow the agents of Mon Health Hospital System to draw a sample of my blood for testing in the Multiphasic Health Screening and/or Prostate-Specific Antigen (PSA) and/or Thyroid Stimulating Hormone (TSH) and/or Glucose A1-C screening. I understand that these tests are for screening only. If there are abnormalities, it will be my sole responsibility to seek further evaluation and treatment as recommended. I understand it is not uncommon to experience some bruising (hematoma) at the site where the needle entered my arm for the blood specimen collection. By way of my signature below, I release Mon Health Medical Center, Mon Health Hospital System, Inc., their respective directors, officers, agents and employees from liability arising from this blood draw.

Notice of Privacy: I understand that the Mon Health Hospital System Privacy Notice that describes how my health information may be used for the purpose of treatment and/or payment of health care operations will be available to me at the site of my blood draw.

Signature_____ Date _____

REGISTRATION FORM AND PAYMENT MUST BE RECEIVED BY October 4, 2019