

AERODIAGNOSTICS LLC™

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Website: aerodiagnosics.com | Email: customerservice@aerodiagnosics.com

Laboratory Requisition

Kathleen O'Neil-Smith, M.D. Medical Director

Welcome to Aerodiagnosics!

1. You received this Aerodiagnosics breath test collection kit because either you or your clinician ordered it.
2. Call the Aerodiagnosics Laboratory directly at **1-617-608-3832** with any questions regarding this test (eg. How to use the kit, cost, test preparation, this form).
3. See the reverse side of this form for a link to the Aerodiagnosics website to view our "How to take an Aerodiagnosics breath test" three (3) minute video.
4. Complete this form and return it with your breath specimens. This form will be attached to the original order we have on file.
5. Utilize this form to make any changes to your personal information.
6. Please be sure to sign and date this form in the designated space at the bottom to authorize Aerodiagnosics to perform this test.

Your Physician/Clinician's Name:

Patient Information

Date of Test: _____ Gender: (Circle One) **Female** **Male** SSN: (Optional) _____

Patient Name (Print; First, Middle, Last): _____

Address: _____

City: _____ State: _____ ZIP: _____ Date of Birth: _____

Home Phone: _____ Work: _____ Cell: _____

E-Mail: _____

Credit Card Payment Information



Credit Card (Check one): Visa Mastercard AMEX Discover Other _____ Billing Zip Code: _____

Credit Card Number: _____ Expiration: _____ Security Code: _____

Name as it appears on the Credit Card:

Patient Primary Insurance & Subscriber Information

(Please attach a copy of the patient's insurance card - front & back)

Insurance Carrier: _____ Subscriber's Date of Birth: ____ / ____ / ____

Insurance ID#: _____ Group ID#: _____

Address for Claims: _____

City: _____ State: _____ Zip: _____ -

Name of Insured/Subscriber (If different from patient): _____

Relationship to Patient: _____ Address: _____

City: _____ State: _____ Zip: _____ -

Signature of Patient or Authorized Responsible Party

I acknowledge that Aerodiagnosics™ may contract with insurance companies and will file claims to my insurance company on my behalf.
I agree that if my insurance company denies the claim(s), does not pay the claim in full, or if I have not met my deductible, I will be responsible for payment of \$199.74 to Aerodiagnosics LLC™.
I acknowledge that I may receive an explanation of benefits (EOB) letter from my insurance company following the filing of the claim(s) by Aerodiagnosics LLC™ for services rendered.
I understand that my insurance company may send payment for this test directly to me. I agree that if this happens I will forward that payment directly to Aerodiagnosics LLC™. I may also send a personal check, money order, bank check, or pay by credit card to Aerodiagnosics LLC™ for the full amount sent to me by my insurance company.
Aerodiagnosics LLC™ offers payment plans for services rendered. Contact customerservice@aerodiagnosics.com for more details.
Aerodiagnosics LLC™ is available at 1-617-608-3832 to answer any payment or insurance questions. Aerodiagnosics LLC™ is also available to answer questions regarding explanation of benefit letters.
I agree to return this test kit to Aerodiagnosics LLC™, even if I have not taken the test, using the pre-paid/self-addressed shipping label included in the test kit.
I understand that I am responsible for payment of \$59.95 to Aerodiagnosics LLC™ for this test kit should I not return the test kit within 60 days.
I authorize Aerodiagnosics LLC™ to release all medical information required to my insurance company(s) for the payment of services rendered by Aerodiagnosics LLC™. I also
I authorize Aerodiagnosics LLC™ to charge my credit card for the amount designated.
I authorize the release of all information related to this order to the listed physician(s) and their designee(s) to facilitate test(s) processing and billing for services rendered.

X

Date: _____

(Signature Required or Test Cannot Be Processed)

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