# Patient Consent Form

TeQuaidas Diagnostics
Mobile Phlebotomy & Diagnostic Services

## Patient Information

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_\_\_

## Consent for Services

I, the undersigned, voluntarily consent to receive phlebotomy and/or diagnostic collection services from TeQuaidas Diagnostics, a mobile healthcare provider. I understand that these services may include but are not limited to:

- Blood draws (venipuncture)
- Specimen collection (urine, saliva, stool, etc.)
- Biometric screenings
- Other diagnostic testing procedures

## Acknowledgements and Disclosures

1. 1. Risks and Benefits

I understand that procedures like blood draws may involve minor risks, such as discomfort, bruising, fainting, or infection. I acknowledge that the staff at TeQuaidas Diagnostics are trained and certified to minimize such risks.

1. 2. Privacy and HIPAA

I understand that my health information will be protected under HIPAA regulations. I authorize TeQuaidas Diagnostics to collect, use, and share my health information with authorized labs, physicians, and insurance providers for the purpose of diagnosis, treatment, or payment.

1. 3. Right to Refuse or Withdraw

I have the right to refuse or withdraw consent at any time without affecting my ability to receive future care.

1. 4. Billing and Insurance

I acknowledge that I am responsible for any charges not covered by my insurance or third-party payers. I understand I may receive a separate bill from the lab processing my specimens.

1. 5. Mobile Services

I understand that TeQuaidas Diagnostics is a mobile provider and may perform services at my home, workplace, or community setting with proper precautions and professionalism.

## Consent Signature

Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian Signature (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witness/Staff Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_