

ORDER and PAYMENT FORM

I am aware that I may make all decisions relating to my health care, no matter how large or small that decision. I want personal education and blood tests performed before my next visit with a doctor.

Client Name: _____
Client Date of Birth (MM/DD/YY) _____ **Phone** _____
Billing Location _____
City / State / Zip _____

I declare that I hold Sunshine Specialties Inc harmless in all events that may arise from drawing, transporting and testing my blood that I desire to have done, by my own free will for my knowledge, education, health and research purposes. In witness whereof, I affix my original signature.

CLIENT SIGNATURE _____
Parent or Guardian if under 18, please print name here: _____

I wish to order the following services (Lab prices include consult review & one followup):

- _____ Consult Only – I am completing all quizzes only, and want no labs. \$65 x _____ = \$ _____
- _____ Consult Only – I am self-ordering labs through Direct Labs. \$65 x _____ = \$ _____
- _____ Lab: Comprehensive Wellness Profile + Magnesium \$195
- _____ Lab: Comprehensive Wellness Profile + Magn. + ABO Blood Typing \$240
- _____ Lab: Family Comprehensive Wellness Profile + Magnesium \$155 x _____ = \$ _____
- _____ Lab: Family Comp. Wellness Profile + Magn. + ABO Blood Typing \$200 x _____ = \$ _____
each family member must complete and sign all forms including this one, with one total payment for all.
- _____ Additional Labs Desired _____ please confirm = \$ _____

- _____ I am enclosing \$ _____ cash for the above services.
- _____ I am enclosing \$ _____ check# _____ for the above services.
- _____ Please charge \$ _____ to my credit card.

___ Discover ___ Visa ___ MasterCard
 _____ - _____ - _____ - _____ V-Code _____ Expires ___/___

___ American Express
 _____ - _____ - _____ - _____ V-Code _____ Expires ___/___

Cardholder Signature _____

Client information is held within strictest confidentiality. Sunshine Specialties Inc reserves the right to refuse service to anyone. 812-482-7868; 601 Newton Street; Jasper, Indiana 47546. Prices and availability subject to change without notice. Effective 08/01/2015. These statements have not been evaluated by the Food and Drug Administration. These products are not intended to diagnose, treat, cure or prevent any disease.

Authorization for Release of Medical/Health Information

Patient Name _____
Date of Birth _____

I authorize DLS to release health information electronically (email or fax) or paper to:

Sunshine Specialties Inc / Desiree Yoder / Donna Yoder

Name of person or facility to receive health information

601 Newton St, Jasper IN 47546

Street Address, City, State, Zip

812-482-7868

Phone

INFORMATION TO BE RELEASED

Laboratory Report(s) Date of Report _____

Requisition Number _____

Billing Statements

SIGNATURE

(Signature of Patient or Patient's legal representative)

Date _____

Printed Name _____