Client Agreement and Consent to Drug and / or Alcohol Testing

I, _____________________________________, hereby agree, under the drug/alcohol testing agreement between Quest Diagnostics and Muskingum Behavioral Health, to submit to a drug or alcohol test and to furnish a sample of my urine. I further authorize and give full permission to have Muskingum Behavioral Health send the specimen or specimens so collected to Quest Diagnostics for a screening test for the presence of any legal or illicit substances, and for the laboratory or other testing facility to release any and all information regarding lab results to Muskingum Behavioral Health.

I understand that only authorized individuals will have access to information furnished or obtained in connection with the test; that they will maintain and protect the confidentiality of such information to the greatest extent possible; and that they will share such information only to the extent necessary and in compliance with the regulations of HIPAA and 42 C.F.R. Part 2.

I will hold harmless Quest Diagnostics and Muskingum Behavioral Health, meaning that I will not sue or hold responsible such parties for any alleged harm to me that might result from such testing, including loss of employment or any other kind of adverse job action that might arise as a result of the alcohol or drug test, even if one of these parties should make an error in the administration or analysis of the test or the reporting of the results. I will further hold harmless Muskingum Behavioral Health and Quest Diagnostics for any alleged harm to me that might result from the release or use of information or documentation relating to the drug or alcohol test, as long as the release or use of the information is within the scope of this policy, procedures and the federal privacy laws as explained in the paragraph above.

This policy and authorization have been explained to me in a language I understand, and I know that if I have any questions about the test or the policy, they will be answered. **For any billing and financial assistance inquiries, please call Quest Diagnostics at 866-MYQUEST (866-697-8378). Link to Financial Assistance Form: http://www.questdiagnostics.com/home/about/corporate-citizenship/community-giving/assistance.html**

_________________________________ _____________________________

Client Signature Date

_________________________________ _____________________________

Parent / Guardian Signature (if client under 18 y.o.) Date

_________________________________ _____________________________

Employee Signature Date

Quest Diagnostics

Dear Patient,

Thank you for your interest in our Patient Financial Assistance Program. So that we can determine your eligibility, please complete the attached application form and return it to the correspondence address listed on your invoice, along with one or more of the required documents listed below:

- A copy of last year's W2 form
- A copy of last year's income tax return
- A copy of your most recent pay stub (s)
- A proof source indicating that you are eligible for local, state, or federal assistance programs.

Once we receive your completed application and documentation, we will determine if you meet the established criteria. Please allow approximately two weeks for your application to be processed. Do not make any payments until you receive notification regarding the status of your request. Applying for acceptance into our Financial Assistance Program does not guarantee reduced charges.

If you have any additional questions or concerns, please do not hesitate to contact us. Thank you for using Quest Diagnostics. We look forward to serving you in the future.

Sincerely,

Patient Billing Customer Service

Quest Diagnostics

Patient Financial Assistance Form

***Patient Name:*___________________________ *Telephone Number:*_______________**
***Address:*______________________________________ *Patient Date of Birth:* _______**
***City:*___________________________________ *State:* ______ *Zip Code:* _____________**
***Invoice Number(s):*____*Lab Code:*____________**

Please complete all information accurately. The signature of the patient or patient's guardian is required.
<u>Please make sure to attach the required supporting documentation.</u>

1. Does the patient have sufficient resources to pay for the testing and/or the deductible and coinsurance?
   - ☐ Yes If answer is "Yes", you are financially responsible for payment.
   - ☐ No If answer is "No", complete form below.

2. Is any source, other than the patient, legally responsible for the patient's medical bills (***e.g.***, Medicaid, local welfare agency, guardian or other insurance program)?
   ☐ Yes ☐ No If answer is "Yes" list:
   Insurance Company Name: ____
   Address: ____
   Member I.D.: ____
   Other Source: ____

3. Patient/legal guardian's monthly resources:

Salary	$___________________
Social Security	$___________________
Cash/Welfare Payment	$___________________
Family Contribution	$___________________
Income from Savings Accounts, CDs, etc.	$___________________
Other	$___________________
Total	**$____________________**

4. Number of family members in household: _________

I hereby acknowledge that the above information is true and correct according to the best of my knowledge and belief. I also authorize the release of any and all financial records necessary to verify the above information. I understand that if I do not qualify, I will be notified and Quest Diagnostics will bill me. I hereby acknowledge that I am neither related to nor employed by the physician who ordered the testing.

Patient Name (Print): ____
Guardian Name (Print): ____
Responsible Party Signature: ____
Date: ____

For Official Use Only:

Bill Number	Amount $	Approved	Denied
Date Received:			
PCS Rep:			
Supervisor (signature):			