quadrant laboratories
505 Irving Ave, Ste 3733, Syracuse, NY 13210
O: (866) 240-4485. F: (315) 666-1379

INFORMED CONSENT & AUTHORIZATION

PATIENT INFORMATION		
Legal First Name	**Legal Last Name**	**Patient DOB** (MM/DD/YYYY)

Please submit separate signed general consent form for each sample submitted (1 form per patient)

CONSENT TO TEST

I, (insert parent's legal name) _____, hereby request genetic testing for me/or my dependent which may include genetic molecular or biochemical analyses (test name provided above). No tests other than those authorized by myself and my doctor will be performed and reported on my sample. I have received verbal and/or written information from my physician or from a genetic counselor that described, in words that I understood, the nature of the genetic testing that I/my dependent is about to undergo. I understand that a specimen(s), such as peripheral blood, saliva, cheek swab, dried blood spot, skin biopsy, amniotic fluid, chorionic villi, and/ or urine sample will be taken from me/my dependent. I understand that the samples will be used for determining if I/my dependent have a genetic disease/disorder, are carriers of a genetic disease/disorder, or are more susceptible to developing a genetic disease/disorder or medical condition.
The nature of the genetic testing has been explained to me and the accuracy of the test and its risks and limitations have been detailed by my physician and as detailed in the test brochure provided above. I understand that:

- Although the likelihood of an incorrect diagnosis or a misinterpretation of the result is extremely small, infrequent errors may occur. If the true biological relationships of the family members involved are not as I have stated, this test may detect non-paternity. The likelihood of this occurring has been estimated to be less than 1%.
- This testing may yield results that are of unknown clinical significance and parental or other relative's specimens may also be tested to determine whether a specific finding was inherited. An error in the diagnosis may occur if the true biological relationships of the family members involved in this process are not as I have stated and this test may detect non-paternity.
- The results of my/my dependent's test will be explained to me by a genetic counselor or by my physician who will have the opportunity to discuss my results with a geneticist. I have had the opportunity to have all of my questions answered. If I am signing this form on behalf of a minor for whom I am the legal guardian, I am satisfied that I have received enough information to sign on his or her behalf.
- The results of my/my dependent's test will be explained to me by a genetic counselor or by my physician who will have the opportunity to discuss my results with a geneticist. I have had the opportunity to have all of my questions answered. If I am signing this form on behalf of a minor for whom I am the legal guardian, I am satisfied that I have received enough information to sign on his or her behalf.
- This consent is being obtained in order to protect my right to have all of my questions answered before testing.
- The results of this testing will become part of my medical record and may only be disclosed to individuals who have legal access to this record or to individuals whom I designate to receive this information.
- Other laboratories may provide a similar test, and I have had the opportunity to discuss these options with my physician before choosing Quadrant Laboratories.
- I agree to allow the provider or genetic counselor to utilize all tools available that can search, find, and aggregate my patient history of care, to help provide me with the highest level of care.
- I affirm that I have given consent to my treating physician, to communicate with a specialist about the results of my genetic test.

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Legal First Name	**Legal Last Name**	**Patient DOB** (MM/DD/YYYYY)

USE OF PROTECTED HEALTH INFORMATION

I, as the patient or parent/legal guardian of the patient set forth above, authorize Quadrant Laboratories LLC and its agents (collectively, the "Companies") to access, use, and disclose my/my dependent's protected health information ("Protected Health Information"), including, but not limited to, information relating to my/my dependent's medical condition, treatment, care management, and health insurance, as well as all information provided on this form for activities related to the genetic testing process ("Testing"), including for benefits investigations and prior authorizations, as applicable.

I understand that the laboratory may wish to contact me/my dependent in the future for the following reasons: research purposes, the provision of general information about research findings, and/or the provision of information about the results of tests on my/my dependent's sample(s). I understand that I may notify the laboratory to opt out of such future contact.

RESEARCH

I give consent to have my/my dependent's specimen anonymously used for laboratory quality improvements, and scientific research related to genetic disease/disorder and stored for as long as the specimen is useful for such purposes, and that I/my dependent will receive no compensation in connection with such research. Quadrant may also share the de-identified information with its research partners and may submit this de-identified information to research databases for use in scientific and medical research, including scientific databases that are maintained by the federal government. My de-identified information may be used for future research purposes. I understand that I may withdraw this consent at any time and that my/my dependent's specimen will be promptly destroyed; provided however, that actions taken in reliance of this consent may not be cured.

_____ By initialing here, I agree to have my/my dependent's de-identified health information used in research databases consistent with this consent. Alternatively, I may opt-in to this by contacting Quadrant by email at support@quadrantlaboratories.com.

For New York State Residents Only

_____ By initialing here, I confirm I am a New York State Resident and I give permission for Quadrant Laboratories to retain any leftover sample for more than 60 days after the completion of testing so that it can be used as a de-identified sample for test development, quality assurance, and validation purposes. Otherwise, New York State law requires Quadrant Laboratories to destroy my sample after 60 days.

ACKNOWLEDGEMENT

revocation will not apply to any information already used or disclosed in reliance of this Authorization. I understand that I may refuse to sign this Authorization and that refusing to sign this Authorization will not change the way Quadrant Laboratories treats me. I also understand that if I do not sign this Authorization, my dependent will not be able to receive the test.

SIGN HERE

_____ Parent/Guardian signature

_____ Parent/Guardian printed name

_____ Date MM/DD/YYYY

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Financial Responsibility & Consent Form

PATIENT INFORMATION		
Legal First Name	**Legal Last Name**	**Patient DOB** (MM/DD/YYYYY)

QUADRANT LABORATORIES, LLC FINANCIAL POLICY

We are committed to providing you with the best care possible.
Your clear understanding of the financial policy agreement is important to our professional relationship.

Insurance

1. It is the responsibility of the financially responsible individual to provide accurate and timely insurance information. Inaccurate or untimely information given to the staff that results in denial or noncoverage by your insurance company results in the financially responsible individual being responsible for payment.
2. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered. An estimate of the patient responsibility portion may be provided prior to services rendered if requested, although true balance due may differ after the insurance processes the bill.
3. You are responsible for any and all co-payments, deductibles, coinsurances, and non-covered items up to the full billed amount. All insurance carriers have a fee schedule from which they will reimburse. However, the provider's fee may be higher than what the insurance company reimburses, or it may not be a covered service. Therefore, any balances not covered by insurance becomes the responsibility of the financially responsible individual.
4. All services performed will be submitted as a courtesy to your insurance.

Self-pay

1. Full balance of test must be processed prior to a sample kit being delivered.
2. If sample is not returned to the lab within 7 days or the sample is not viable, Quadrant Laboratories will work with you to resolve the issue and/or refund the balance paid upon request.

Financial Responsibility

1. If previous arrangements have not been made with our billing office, any account balance outstanding longer than 180 days may be forwarded to a collection agency.
2. The parent or adult signing this consent is financially responsible for any balances due. In case of divorce, please do not place our office in the middle of marital disputes. It is your responsibility to work out the payment of your child's medical care between the custodial and noncustodial parent.
3. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact our billing department promptly for payment arrangements and assistance in the management of your account.

Phone: 866-240-4485
Email: Support@quadrantlaboratories.com

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY SET FORTH BY QUADRANT LABORATORIES. I AGREE THAT IF IT BECOMES NECESSARY TO FORWARD MY ACCOUNT TO A COLLECTION AGENCY, I WILL ALSO BE RESPONSIBLE FOR THE FEE CHARGED BY THE AGENCY FOR THE COSTS OF COLLECTION IN ADDITION TO THE ORIGINAL AMOUNT DUE. I UNDERSTAND AND AGREE THAT THE TERMS OF THIS FINANCIAL POLICY MAY BE AMENDED BY QUADRANT LABORATORIES AT ANY TIME WITHOUT PRIOR NOTIFICATION TO THE GUARANTOR.

SIGN HERE

Signature of financially responsible individual

Printed name of financially responsible individual

Date (MM/DD/YYYY)