



**Ambry Genetics understands that out-of-pocket expenses for clinical testing can be cost prohibitive for many patients and their families. Below you will find several common terms and resources.**

I would like Ambry Genetics to contact me if my out-of pocket deductible, co-pay, and or co-insurance will be more than:

Circle one:    \$100                    \$300                    Other: \_\_\_\_\_

\_\_\_\_\_ I choose not to be contacted, please proceed with testing.  
*(Initials)*

Processing of test will be started if my total out-of-pocket expense for deductible, co-pay and co-insurance will be less than the amount indicated above.

**Co-pay-** a payment defined by the insurance company and paid by the insured person each time a medical service is assessed.

**Deductible-** in an insurance policy, this is the portion of a claim that is not covered by the insurance provider.

**Co-insurance-** the percentage that the insured person pays after the deductible is exceeded.

Patient Name: \_\_\_\_\_  
*(Please Print)*

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

Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Please contact me via the following method(s):

Cell Number: \_\_\_\_\_

Home Number: \_\_\_\_\_

Work Number: \_\_\_\_\_

E-mail address: \_\_\_\_\_