Patient Signature Card

Ambry Genetics®
A Konica Minolta Company

Sample Collection Date: _____ Biological Sex: ☐ Male ☐ Female

Provider Name: _____

Patient Name: _____ Patient DOB: _____

I agree to be contacted by:

☐ Email _____

☐ Phone (by checking this box you agree that we can contact you via text) - mobile # _____

Patient Contact:
We will start testing immediately, unless you check the box below. We will attempt to contact you if your estimated out-of-pocket costs are greater than USD $100.

☐ Do not start testing until I approve payment terms regarding estimated out-of-pocket costs.

For NY residents:

☐ I am a New York resident and I give Ambry Genetics permission to store my sample for longer than 60 days. **NOTE:** If left blank, consent is interpreted as "NO".

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Ambry's Patient Assistance Program aims to make genetic testing affordable for all patients. You can elect to be considered for reduced out-of-pocket costs by providing the total annual gross household income: $_____ and the number of family members in the household supported by the listed income: _____. I authorize Ambry Genetics to verify the above information for the sole purpose of assessing financial need, including the right to seek supporting documentation.

Patient Acknowledgement: For direct insurance billing: I authorize my insurance benefits to be paid directly to Ambry Genetics Corporation (Ambry), authorize Ambry to release medical information concerning my testing to my insurer, to be my designated representative for purposes of appealing any denial of benefits as needed and to request additional medical records for this purpose. I understand that I am financially responsible for any amounts not covered by my insurer and responsible for sending Ambry money received from my health insurance company.

I agree to the Patient Acknowledgment above

Patient or Legal Guardian Signature: _____ **Date:** _____