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:
In most cases, we will start testing immediately.* We will attempt to contact you if the estimated out-of-pocket costs are greater than USD $100.

** May vary by test or for patients with government insurance*

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Ambry's Patient Assistance Program aims to make genetic testing affordable for all patients. In order to expedite consideration for eligibility for Ambry's Patient Assistance Program, please provide 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: I acknowledge that the information provided by me is true and correct. 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. For patient payment by credit card: I hereby authorize Ambry Genetics Corporation to bill my credit card as indicated on Ambry's Test Requisition Form.

I agree to the Patient Acknowledgment above

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

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