Patient Signature Card

Ambry Genetics

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

Provider Name: _____

Patient Name: _____ Patient DOB: _____

I agree to be contacted by:

☐ Email: _____

☐ Phone: _____

If this is a mobile phone number, you agree that we can contact you via text message and data rates may apply.

What is the Sample Collection Date?
Complete this field with the date that you (or your medical provider) filled the collection tube(s) with blood/saliva/collection swabs.

Why do I need to provide at least one contact method?
We will need to contact you directly if we have questions concerning your insurance, and to provide you an estimate of your out-of-pocket costs.

Accessioning Sticker Here

Contact billing@ambrygen.com or 949-900-5500 if you have questions.

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Ambry Genetics®

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.

I agree to the Patient Acknowledgment above

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

 MKT-CORP-FORM-10078-EN v13 | 05.13.23

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