Patient Signature Card

FOR AMBRYPORT ORDERS - SEE REVERSE

Ambry Genetics®
A Konica Minolta Company

Patient Name: _____ Patient DOB: _____

Patient agrees 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.

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.

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".

I agree to the terms and conditions (see reverse)

Patient or Legal Guardian Signature: _____ Date: _____

How To Use This Card

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1. **Order and submit** test on AmbryPort™
2. Collect and label blood or saliva from patient
3. Complete Patient Signature Card and have patient sign it
4. Package signature card, sample, and any other documents into Sample Submission Kit
5. Place Sample Submission Kit in FedEx bag, seal, affix FedEx Billable Stamp, and mail

Provider Name: _____