BioReference® | GenPath®

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NOTICE OF PATIENT FINANCIAL RESPONSIBILITY

I, _____ (Patient Name) understand that BioReference Health, LLC. only offers ***OnkoSight Advanced™ 523 Gene NGS Re-Analysis with PerianDx*** on a self-pay basis. By signing below, I have elected not to submit any invoice or claim for reimbursement to any insurer or health plan (including but not limited to Medicare, Medicaid, or any private health insurer or plan) and acknowledge that I wish to obtain this testing on a self-pay basis. Therefore, I agree and understand that the testing purchased that I will be solely financially responsible for payment of the testing and shall not submit a claim to any insurer or health plan.

I understand that I may be able to submit the expense associated with this testing to my Health Savings Account, Flexible Spending Account, Health Reimbursement Account, or similar account for reimbursement. I understand that it is my responsibility to check with my health account administrator to see if this expense is eligible for reimbursement under my Health Savings or other similar account.

I understand that I will receive and be financially responsible for a bill from BioReference Health, LLC for this testing in the amount of $200.00 dollars.

_____

Print (Patient)

_____ _____

Signed (Patient) Date