LAB FORM INSTRUCTIONS

TO: Those interested in ordering lab tests
FROM: Melinda Ballard DATE: May 16, 2006

POA has secured for your benefit a hefty discount for lab services conducted by RealTime Labs. To get the discount, please follow the instructions, print off forms and give your physician the forms he/she needs. These forms include:

1. ***Procedures for lab tests***: This includes instructions. Give this to your physician.

2. ***Requisition form***: This MUST be filled out by your physician. The physician must mark which test(s) he/she is ordering. Give this to your physician. Obviously, your physician should order the tests that correspond to the molds found in your home. Consult table below:

MOLD SPECIES IDENTIFIED IN HOME	MYCOTOXIN ASSOCIATED WITH MOLD SPECIES	RECOMMENDED LAB TESTS/POA DISCOUNTED PRICE
Aspergillus flavus, Asperfillus parasiticus, Other Aspergillus species	Aflatoxin; Aflatoxin; Aflatoxin	To test for mycotoxins order test number E8502 for Aflatoxin Group.* To test for DNA order test number E8310 for Aspergillus Panel. To test for specific species order test numbers E8600, E8601, E8602, or E8603 for a One-Probe Panel, Three-Probe Panel, Four-Probe Panel, or Five-Probe Panel. (Mark specific species at the bottom of requisition form.)
Aspergillus ochraceus; Penicillium viridictum	Ochratoxin; Ochratoxin	To test for mycotoxins order test number E8501 for Ochratoxin Group.* To test for DNA order test number E8310 for Aspergillus Panel or test number E8330 for Penicillium Panel. To test for specific species order test numbers E8600, E8601, E8602, or E8603 for a One-Probe Panel, Three-Probe Panel, Four-Probe Panel, or Five-Probe Panel. (Mark specific species at the bottom of requisition form.)
Stachybotrys sp.; Fusarium sp.; Trichoderma sp.	Trichothecene; Trichothecene; Trichothecene	To test for mycotoxins order test number E8503 for Tricothecenes Group. To test for DNA order test number E8350 for Stachybotrys Panel and test number E8600 for a One-Probe Panel for Fusarium. To test for both panels order E8601 for a Three-Probe Panel. (Mark specific species at the bottom of requisition form.)

*** If mold identification is reported as Aspergillus/Penicillium both Aflatoxin and Ochratoxin should be tested for.**

Policyholders of America
15 Orange Street Charleston, SC 29401
Writer's direct line: (843) 723-0710 Writer's direct fax: (843) 723-0711

3. ***Price list***: This form spells out the charges for each lab test. You will receive a 10% discount off of these normal charges. You will need this price list to determine how much you owe. Once the tests needed are marked on the Requisition Form by your doctor, you should tally up the total cost. Reduce the total by 10% -- that is the total due to the lab.

The lab requires advanced payment, either by check (send check in package with specimens) or by credit card. If you are using your credit card, fill out and send the credit card authorization form to the lab. DO NOT SEND THIS FORM TO POA. The credit card authorization form can be faxed to RealTime Labs or sent in package with specimens (see below)

4. ***Credit Card Authorization form:*** This form must be filled out by you – the patient – if you are paying the lab fees by credit card. Fax this form to RealTime Labs at 214-890-1198 or send the discounted fee total by check, along with the specimens sent by your physician, to RealTime Labs. DO NOT SEND THIS FORM TO POA! POA does not suggest you allow your doctors office staff to have access to this form therefore, we do not recommend you send the credit card authorization form together with your specimens. This is strictly for security reasons.

5. ***Medicare Notice*** (ABN): This form is for those on Medicare. Basically, it forewarns Medicare beneficiaries that Medicare typically won't pay for these services. Big surprise.

If your physician has questions, please direct all inquiries to RealTime at 214-764-1160.

Good luck and let POA know if there is anything we can do to help!

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PROCEDURES FOR LABORATORY TESTS SENT TO REALTIME LABORATORIES, LLC

1. Patient must be informed that some tests may not be covered by either private or Medicare insurance. Have the patient sign and date a Laboratory Advance Beneficiary Notice (ABN). **The ABN must accompany the Laboratory Requisition Form.**

2. Inform the patient of your office procedures for payment. If the patient is using a credit card for payment, have the patient sign a Credit Card Authorization Form. Send this form with the Laboratory Requisition Form.

3. Obtain the appropriate specimen for the test being ordered. Urine must be first morning void.

4. Complete the Laboratory Requisition Form and make a copy for your files.

5. Pack and ship specimens to RealTime Laboratories, along with the Laboratory Requisition Form, the ABN, and billing information (filled out Credit Card Authorization or check). **Ship Overnight.**

Address: RealTime Laboratories
Attn: Dr. Dennis Hooper
8325 Walnut Hill Lane, Suite 125
Dallas, Texas 75231
Phone: 214-764-1160 Fax: 214-890-1198

6. Results will be faxed to the ordering physician.

REALTIME LABORATORIES, LLC

8325 Walnut Hill Lane, Suite 125
Dallas, TX 75231
Phone: 214-764-1160 Fax: 214-890-1198
CLIA #: 45D1051736
E-Mail: mscmd@cox.net

Paid: ______
Date: ______
Init: _______

REQUISITION FORM

(To Be Filled Out By Physician)

Patient Name: ____________________ **Accession #:** ____________________

Sex: ____________ **DOB:** ____________ **ID #:** ____________

Specimen Source: ____________________ **Date & Time Collected:** ____________________

DX: ____________________ **Doctor:** ____________________

MARK ORDERED LAB TEST:

Test Ordered	Test Code	Specimen Type	Name of Test
	E8300	DNA Tissue/Fluid	Total DNA Tissue/Fluid Panel (All 23 Probes)
	E8310	DNA Tissue/Fluid	Aspergillus Panel (10 Probes)
	E8330	DNA Tissue/Fluid	Penicillium Panel (10 Probes)
	E8600	DNA Tissue/Fluid	One-Probe Panel (Select any 1 probe from below list)
	E8601	DNA Tissue/Fluid	Three-Probe Panel (Select any 3 probes from below list)
	E8602	DNA Tissue/Fluid	Four-Probe Panel (Select any 4 probes from below list)
	E8603	DNA Tissue/Fluid	Five-Probe Panel (Select any 5 probes from below list)
	E8350	DNA Tissue/Fluid	Stachybotrys Panel
	E8500	Mycotoxin Tissue/Fluid	Total Mycotoxin Tissue/Fluid Panel
	E8501	Mycotoxin Tissue/Fluid	Ochratoxin Group (A)
	E8502	Mycotoxin Tissue/Fluid	Aflatoxin Group (B1, B2, G1, and G2)
	E8503	Mycotoxin Tissue/Fluid	Tricothecenes Group (Roridin A, E, H and L-2, Satratoxin G and H, Isosatratoxin F, Verrucarin A and J, and Verrucarol by Enzyme Linked Immunoassay (ELISA))
	E9000	Skin Tissue/Fluid	Fungal Culture and Final ID
	E9100	Blood (see below) *	Immunophenotyping by Flow Cytometry

*** EDTA tube and yellow top tube (solution A) required. Accepted Monday through Thursday, 8 a.m. to 4 p.m. and Friday, 8 a.m. to 12 p.m.**

Probe Ordered	Aspergillus Panel
	E amstelodami
	A flavus
	A fumigatus
	E nidulans
	A niger
	A ochraceus
	A parasiticus
	A sydowii
	A ustus
	A versicolor

Probe Ordered	Stachybotrys Panel
	S chartarum
	S echinata
	Fusarium Panel
	F solani

Probe Ordered	Penicillium Panel
	P aurantiogriseum
	P chrysogenium
	P citrinum
	P corylophilum
	P crustosum
	P expansium
	P fellutanum
	P roquefortii
	P simplisticum
	P verrucosum

NOTE:

1. **Medicare patients require ABN (Advance Beneficiary Notice) to be signed prior to test being performed. ABN must accompany laboratory requisition form. Thank you.**
2. **Check or credit card authorization form to accompany each requisition.**

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REALTIME LABORATORIES, LLC

8325 Walnut Hill Lane, Suite 125
Dallas, Texas 75231
Phone: 214-764-1160 Fax: 214-890-1198
E-Mail: mscmd@cox.net
CLIA #: 45D1051736

PRICE LIST

TEST CODE	SPECIMEN TYPE	NAME OF TEST	PRICE
E8300	DNA Tissue/Fluid	Total DNA Tissue/Fluid Panel (23 Probes)	$3,085.00
E8310	DNA Tissue/Fluid	Aspergillus Panel (10 Probes)	$1,933.00
E8330	DNA Tissue/Fluid	Penicillium Panel (10 Probes)	$1,933.00
E8600	DNA Tissue/Fluid	One-Probe Panel	$304.00
E8601	DNA Tissue/Fluid	Three-Probe Panel	$590.00
E8602	DNA Tissue/Fluid	Four-Probe Panel	$784.00
E8603	DNA Tissue/Fluid	Five-Probe Panel	$967.00
E8350	DNA Tissue/Fluid	Stachybotrys Panel	$579.00
E8500	Mycotoxin Tissue/Fluid	Total Mycotoxin Tissue/Fluid Panel	$1,100.15
E8501	Mycotoxin Tissue/Fluid	Ochratoxin Group (A)	$398.00
E8502	Mycotoxin Tissue/Fluid	Aflatoxin Group (B1, B2, G1, and G2)	$398.00
E8503	Mycotoxin Tissue/Fluid	Tricothecenes Group (Roridin A, E, H and L-2, Satratoxin G and H, Isosatratoxin F, Verrucarin A and J, and Verrucarol by Enzyme Lined Immunoassay (ELISA))	$320.00
E9000	Skin Tissue/Fluid	Fungal Culture and Final ID	$125.00
E9100	Blood (see below) *	Immunophenotyping by Flow Cytometry	$700.00
E9110	Blood (see below) *	Flow Cytometry with Mitogen Stimulation	$850.00

*** EDTA tube and yellow top tube (solution A) required. Accepted Monday through Thursday, 8 a.m. to 4 p.m. and Friday, 8 a.m. to 12 p.m.**

NOTE:

1. **Medicare patients require ABN (Advance Beneficiary Notice) to be signed prior to test being performed. ABN must accompany laboratory requisition form. Thank you.**
2. **Check or credit card authorization form to accompany each requisition; Credit card authorizations can be faxed to lab.**
3. **Payment must be made prior to testing.**
4. **POA members: Discount published price(s) by 10% to arrive at total fees due to lab.**

REALTIME LABORATORIES, LLC
8325 Walnut Hill Lane, Suite 125
Dallas, Texas 75231
CLIA#: 45D1051736
Phone: 214-764-1160 Fax: 214-890-1198

CREDIT CARD AUTHORIZATION

(To Be Filled Out By Patient)

This authorizes Medical Service Consultation, P.A. to debit the following credit card for RealTime Laboratories, LLC fees for laboratory tests it performs until I notify the clinic that the authorization is no longer valid. I accept responsibility for payment of all charges incurred and placed on this credit card.

Credit Card (AMEX, Visa, MasterCard): ______________________________

Number: ____

Expiration Date: ____

Authorization Signature: ____

Please print name: ____

Address (where card receives its bills):

Street: ____

City: ____

State and Zip: ____

Phone Number: ____

PAYMENT MUST BE MADE IN ADVANCE OR LAB RESULTS WILL NOT BE REPORTED.

Please fax to Mo (Billing Department) at 214-890-1198 or send with specimen.

REALTIME LABORATORIES, LLC
8325 Walnut Hill Lane, Suite 125, Dallas, TX 75231
Phone: 214-764-1160 CLIA #: 45D1051736
(To Be Filled Out By Patient)

Patient's Name: Medicare # (HICN):

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these laboratory tests.

We expect that Medicare will not pay for the laboratory test(s) that are described below. Medicare does not pay for all of you health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for the laboratory test(s) indicated below for the following reasons:**

Medicare does not pay for these tests for your condition	Medicare does not pay for these tests as often as this (denied as too frequent)	Medicare does not pay for experimental or research use tests
E8300 Total DNA Tissue Panel		X
E8310 Aspergillus Panel		X
E8330 Penicillium Panel		X
E8600 One-Probe Panel		X
E8601 Three-Probe Panel		X
E8602 Four-Probe Panel		X
E8603 Five-Probe Panel		X
E8350 Stachybotrys Panel		X
E8500 Total Mycotoxin Tissue/Fluid Panel		X
E8501 Ochratoxin Panel		X
E8502 Aflatoxin Panel		X
E8503 Tricothecenes Panel		X
E8700 Total Interleukin/Interferon Gamma Panel		X
E8710 Interleukin-5 (IL-5)		X
E8720 Interleukin-13 (IL-13)		X
E8730 Interferon Gamma		X
E9000 Fungal Culture and Final ID		X
E9100 Immunophenotyping by Flow Cytometry		

The purpose of this form is to help you make an informed choice about whether or not you want to receive these laboratory tests, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these laboratory tests will cost you **(Estimated Cost: $__________)**, in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ **Option 1. YES. I want to receive these laboratory tests.**
I understand that Medicare will not decide whether to pay unless I receive these laboratory tests. Please submit my claim to Medicare. I understand that you may bill me for laboratory tests and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

☐ **Option 2. NO. I have decided not to receive these laboratory tests.**
I will not receive these laboratory tests. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay. I will notify my doctor who ordered these laboratory tests that I did not receive them.

Date **Signature of patient or person acting on patient's behalf**

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

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