

Patient Self-Pay Testing Option

Patient Name: _____ DOB: _____

Physician: _____

CombiMatrix offers the following rates for patients without insurance. Please check the box that corresponds to the testing desired. **Please include this form with patient sample.**

Indicate Test Selected (√)	Laboratory Test	Self-Pay Price
	Acetylcholinesterase (AChE)	\$ 105.00
	Alpha-Fetoprotein (AFP) Amniotic Fluid	\$ 60.00
	Chromosome Analysis Amniotic Fluid	\$ 850.00
	Chromosome Analysis Chorionic Villus Sampling (CVS)	\$ 850.00
	Chromosome Analysis Peripheral Blood	\$ 850.00
	CombiFISH™ Analysis Peripheral Blood	\$ 350.00
	CombiSNP™ Array Pediatric Analysis	\$ 1,250.00
	CombiSNP™ Array Prenatal Analysis	\$ 1,250.00
	CombiSNP™ Array Products of Conception Analysis	\$ 1,250.00
	Fragile X Pediatric Analysis	\$ 470.00
	Fragile X Prenatal Analysis	\$ 413.00
	Maternal Cell Contamination Studies Prenatal Analysis	\$ 280.00
	Total	

If you have any questions regarding the tests offered by CombiMatrix or the self-pay pricing options, please contact CombiMatrix Client Services at 800.710.0624 x455.

Please make check or money order payable to CombiMatrix.

- Personal Check
 Cashier's Check
 Money Order
 Credit Card:
 MasterCard
 Visa
 American Express
 Discover

Credit Card Number: _____ Exp. Date: _____

Name on Card: _____ Security Code (CCV): _____

Signature: _____ Charge Amount: _____

Date: _____

Beneficiary Agreement:

I consent to these laboratory studies and agree that I am fully and personally financially liable for the payment of these services.

Patient Name: _____

Patient Signature: _____ Date: _____