arcpoint labs
accurate. reliable. confidential testing.

Drug Alcohol DNA Wellness LabTests Background

Client Intake Form

Full Legal Name: _____ Date: _____
Date of Birth: _____ Sex: □ Female □ Male
Race: _____ Ethnicity: □ Hispanic/Latino □ Non-Hispanic/Non-Latino □ Unknown
Street Address: _____
City: _____ State: _____ Zip Code: _____ County: _____
Phone #: (_____) _____ Email: _____
Allergies: □ Latex □ Alcohol □ Other (please list) _____
Emergency Contact Name: _____ Phone: _____
Method to Receive Results: □ Email/Electronic □ Pick Up
Is the patient pregnant: □ Yes □ No Estimated Due Date: _____
Test(s) Requested: _____

I hereby grant permission to ARCpoint Labs to perform testing or specimen collection for the purpose of conducting certain screening test(s), which may require venipuncture, finger stick, nasal swab or oral fluid collection, as set forth above at my direction. I understand that the actual testing may be performed by ARCpoint Labs or a third-party laboratory.

I understand that the tests requested are for my own use and not for medical diagnostic or treatment purposes. I agree that I am personally financially responsible for payment of fees for all tests ordered and collected by ARCpoint Labs at my request, and I agree will not seek to be reimbursed by Medicare, Medicaid or any other government insurer/payor for the test(s) performed.

I understand that test results reported by ARCpoint Labs will be reported directly to me in the manner I have chosen above, and I understand that it is my sole responsibility to consult my own medical professional for the interpretation, analysis, evaluation, and explanation of my test results in my discretion.

I understand that if testing returns critical values which may indicate a serious medical condition, ARCpoint Labs or a representative thereof will make reasonable attempts to notify me promptly, including by telephone and/or email. I also understand that it is my responsibility to ensure that my contact information is accurate and to notify ARCpoint Labs of any changes.

I agree that ARCpoint Labs, directors, staff, physicians, and/or any agent or employees thereof ("ARCpoint") shall not be liable for any claim arising out of or related to the Services, including but not limited to, inaccurate, un-interpreted, misinterpreted results or results not received and do hereby expressly forever release and discharge ARCpoint from such claims, demands, injuries, damage, or causes of action.

I HEREBY CERTIFY THAT I HAVE READ THE ABOVE ACKNOWLEDGEMENT AND HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENTS. BY SIGNING BELOW, I CONSENT TO UNDERGO THE COLLECTION AND LABORATORY TESTING UNDER THE CONDITIONS SET FORTH HEREIN.

_____ Date: _____
Client Signature (or Legal Guardian)

_____ _____
Printed Name Relationship if signing on behalf of the client

Authorization to E-mail My Test Results

I, the undersigned, authorize ARCpoint Labs to provide my laboratory results directly to me at the e-mail address I have provided above. I also understand that it is my responsibility to notify ARCpoint Labs of any change in this information.

This authorization is only effective for the visit date ("Date") listed on this form. I must submit a new authorization at each visit to ARCpoint Labs if I wish to have future laboratory results sent to me by e-mail.

I understand that ARCpoint Labs has no control over who may have access to the e-mail address I have listed to receive my lab results.

_____ Date: _____

Client Signature (or Legal Guardian)

_____ _____

Printed Name Relationship if signing on behalf of the client

Reportable Conditions

Certain infectious diseases, conditions, and the identity of those who test positive for them, are required by federal and/or state law to be reported to local or state health authorities by ARCpoint Labs, its affiliates, members of their respective clinical staffs, and any third-party laboratories conducting the laboratory tests. The time frames and reporting requirements vary according to the disease or condition

Accordingly, I understand that if I test positive for any infectious disease or condition on the state's list of reportable conditions, including but not limited to COVID-19, my test result *and* my identifying information will be reported to the applicable local or state health authority.

Additionally, I understand that if I test positive for any infectious disease or condition, neither ARCpoint Labs, their staff, or the third-party laboratories that run the laboratory tests, will diagnose, treat, prescribe medications, or refer me for medical treatment. It is my sole responsibility to seek and comply with necessary treatment and all required follow-up with my physician, healthcare provider, or local public health department.

_____ Date: _____

Client Signature (or Legal Guardian)

_____ _____

Printed Name Relationship if signing on behalf of the client