RPRD Diagnostics, LLC
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CLIA# 52D2126222

U.S. PATIENT SELF-PAY POLICY DISCLOSURE

RPRD Diagnostics is a CLIA-certified clinical reference laboratory, located in Milwaukee, WI, hereto referred to as RPRD. To make our testing services accessible to patients lacking healthcare insurance coverage, RPRD offers discounted pricing for patients who are denied coverage, have no insurance, or wish to pay directly without billing the insurance. This self-pay option is available to patients who reside in the United States of America only. RPRD will consistently apply a method of billing, discounting, and collection from these patients. The Patient Self-Pay Policy is detailed below and is subject to periodic review.

1. Patient Self-Pay Choices

A patient can opt into self-pay if they

1) have no health insurance coverage of any kind, including federal and state healthcare programs such as Medicare or Medicaid.

2) have health insurance, but the insurance carrier does not pay for testing ordered by the patient's healthcare provider.

3) have health insurance but decide to forgo insurance billing and is responsible for all payment obligations arising from the ordered testing and guarantees payment for these services.

2. Billing and Refund

1) All self-pay patients will be required to complete the Patient Election to Self-Pay form and pay for the testing fee as shown in Table 1 below, before the testing can be processed in our laboratory. We will send the invoice to the patient's email address provided in the Test Requisition Form. We accept payments from all major credit cards and Health Saving Accounts (HSAs). We reserve the right to refuse to process the testing or deliver the test result if the patient fails to fulfill all payment obligations. Partial payment is currently not accepted; testing services will only commence when full payment is received.

2) All self-pay patients need to sign the Patient Election to Self-Pay form before the testing can be processed. If the responsible party of the patient signs the form, a witness's signature is also required. We accept the electronic version of the signature, including but not limited to a PDF copy with the Adobe Digital ID, scanned, or faxed copy.

3) The self-pay pricing includes one home collection kit, shipping, and handling fee of $50. If the Collection Package has been shipped to the patient and the order is canceled before the test is processed, a refund of $330 for the Precision HealthPGx Panel, $410 for the Psych HealthPGx Panel, and $730 for the WPS testing will be issued to the patient, within 30 days of cancellation. If an order is canceled before the Collection Package is shipped to the patient, the full refund will be issued to the patient within 30 days of cancellation. In the event of sample failure requiring recollection, or if the collection kit is misplaced, the patient will be responsible for a nonrefundable $50 fee per additional Collection Package.

Table 1: Patient self-pay pricing

Tests	Self-pay rate
Precision HealthPGx Panel	$380
Psych HealthPGx Panel	$460
Whole Pharmacogenomics Scan (WPS)	$780

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PATIENT SELF-PAY ELECTION FORM

Patient Name: _____ Patient Date of Birth:_____

I, _____ , the undersigned patient or person responsible for the patient, acknowledge that I understand and agree to the following:

☐**I HAVE health insurance** (initial all three below)**:**

• I am covered by the above-mentioned health insurance plan and the health plan under which I am covered includes benefits for some or all the services provided to me by RPRD Diagnostics.
_____(Initials)

• Despite the covered service, no claims will be submitted to my health insurance plan for services provided to me.

_____(Initials)

• By my election to Self-Pay, any payments I make to RPRD Diagnostics will not be credited towards satisfying any deductible or cost-share I may be subject to under my health insurance plan, unless otherwise permitted under the terms of my health plan in which I am responsible for.
_____(Initials)

OR

☐**I do NOT have health insurance.**

I have read the RPRD Diagnostics Patient Self Pay Policy Disclosure Form, as well as this Election to Self-Pay Form, and have had the opportunity to ask any questions I had about the forms. Any questions I had about this form have been answered to my satisfaction.

I have freely chosen to elect to pay for all services I receive.

_____ _____
Patient or responsible party's signature Date

_____ _____
Patient or responsible party's printed name and relationship (Invoicing) Patient's email address

_____
Witness' signature (only required if the responsible party signs on the patient's behalf.)

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