



"Consistently reliable since 1978...guaranteed!"

6801 Powerline Road
 Fort Lauderdale, FL 33309-2215 USA
 International: (001) (954) 691-2500
 USA Toll Free: (800) 231-9197
 USA Local: (954) 691-2500
 Fax: (954) 691-2505

REQ #

FL License No. 80000 1454
 CLIA No. 10D0284781
 Tax I.D. No. 59-2192736

PATIENT INFORMATION

LAST NAME FIRST NAME M

ADDRESS

CITY STATE ZIP

HOME PHONE

SEX: M

DATE OF BIRTH (DD/MM/YY)

MEDICARE RECIPIENT?
 Primary Secondary

CELL PHONE

F

DATE OF DRAW (DD/MM/YY)

*Tests with asterisk are accepted for Medicare recipients only if Medicare is secondary payor.

PHYSICIAN INFORMATION

ORDERING PHYSICIAN SIGNATURE: _____

DOCTOR ID #

PRIMARY ASSAYS

SPECIMEN REQUIREMENTS: Serum MUST be received by Immuno Labs within 10 days of blood draw in order to guarantee consistently reliable result.

Immuno 1 Bloodprint™ IgG ELISA Food Sensitivity Assay

Check one Panel.....And.....Check one Food Plan

- Standard (115 Foods)
- Kosher (108 Foods)
- Vegetarian (104 Foods)
- Pediatric (88 Foods)
- 4-Day Rotation Food Plan
- Food Combining
- 2-Day Rotation Food Plan

IgE 36 Allergen Airborne & Food Allergy Assays* (Each selection is a separate assay. Check the desired assays.)

- Standard Food/Mold Panel
- Pediatric Panel
- Eastern Combo
- Southern Combo
- Western Combo
- Western Inhalant
- Southwest Inhalant
- Northwest Inhalant
- Southeast Inhalant
- Northeast Inhalant

ADDITIONAL ASSAYS & REFLEX TESTS

Language for Results:

- Candida albicans Assay**
- Additional IgE Food Panel**
- Milk/Egg Sub-Fractions**
- Anti-gliadin Antibody Assay**
- Tissue Transglutaminase Antibody Assay**
- Milk/Egg Sub-Fractions Reflex Only**
- Anti-gliadin Reflex Only**
- tTG Reflex Only**

- English
- Spanish
- Danish
- Norwegian

PAYMENT INFORMATION

- PHYSICIAN PAY
- PATIENT PAY
- INSURANCE PAY*

CREDIT CARD# M/C AMEX VISA DISCOV.

EXP. DATE (MM/YY)

* PLEASE COMPLETE PAGE 2

CREDIT CARD HOLDER'S NAME: LAST NAME FIRST NAME M

CREDIT CARD HOLDER'S SIGNATURE _____



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INSURANCE ASSIGNMENT INFORMATION (Please complete the following when submitting insurance assignment.)

NAME OF INSURED: LAST NAME FIRST M

GROUP NUMBER PATIENT NAME (PLEASE PRINT) _____

RELATIONSHIP TO PATIENT INSURANCE (NON-MEDICARE) NUMBER

NAME OF INSURANCE COMPANY (PLEASE INCLUDE A COPY OF THE FRONT AND BACK OF INSURANCE CARD) INSURANCE CO. TELEPHONE

ADDRESS OF INSURANCE COMPANY

CITY STATE ZIP

ICD-9 CODES (All codes are provided as a courtesy. Please verify description and codes as they change frequently.)

ALVEOLITIS, ALLERGIC	495.9	<input type="checkbox"/>	FATIGUE, CHRONIC	780.71	<input type="checkbox"/>
ARTHRITIS, OSTEO	715.90	<input type="checkbox"/>	GASTRITIS, ALLERGIC	535.40	<input type="checkbox"/>
ARTHRITIS, RHEUMATOID	714.0	<input type="checkbox"/>	GASTROENTERITIS, TOXIC	558.2	<input type="checkbox"/>
ASTHMA, EXTRINSIC	493.00	<input type="checkbox"/>	HEADACHE	346.20	<input type="checkbox"/>
ASTHMA, INTRINSIC	493.10	<input type="checkbox"/>	HEADACHE, MIGRAINE	346.90	<input type="checkbox"/>
AUTISM	299.00	<input type="checkbox"/>	HIVES/URTICARIA	708.9	<input type="checkbox"/>
CANDIDIASIS	112.89	<input type="checkbox"/>	HYPERACTIVITY (CHILD)	314.01	<input type="checkbox"/>
CELIAC DISEASE	579.0	<input type="checkbox"/>	HYPERTENSION	401.9	<input type="checkbox"/>
COLITIS, ALLERGIC	558.3	<input type="checkbox"/>	HYPOGLYCEMIA	251.2	<input type="checkbox"/>
CONSTIPATION	564.00	<input type="checkbox"/>	IRRITABLE COLON	564.10	<input type="checkbox"/>
DERMATITIS/ECZEMA, FOOD	693.1	<input type="checkbox"/>	OTITIS MEDIA	382.90	<input type="checkbox"/>
DERMATITIS/ECZEMA, Non-SPEC	692.90	<input type="checkbox"/>	PSORIASIS	696.1	<input type="checkbox"/>
DERMATITIS, JUVENILE	694.2	<input type="checkbox"/>	RHINITIS, ALLERGIC	477.1	<input type="checkbox"/>
DIABETES	250.0	<input type="checkbox"/>	SINUSITIS	473.9	<input type="checkbox"/>
DYSPEPSIA	536.80	<input type="checkbox"/>	TINNITUS	388.30	<input type="checkbox"/>

PHYSICIAN COMMENTS

INSURANCE AUTHORIZATION

CREDIT CARD INFORMATION MUST BE PROVIDED ABOVE TO GUARANTEE PAYMENT OF ANY OUTSTANDING BALANCE.

AUTHORIZATION: I acknowledge that I am responsible for any unpaid portion of the bill. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related claim. I assign my insurance benefits to Immuno Laboratories, Inc. I authorize any co-payment or deductible to be charged to the credit card above at the time of testing. If my insurance company does not pay the billed laboratory fees within 90 days or if there is a balance owed, I authorize Immuno Laboratories to charge the appropriate fees to the credit card above. If my insurance company mails reimbursement to me directly, I agree to endorse the check (s) "Pay to the order of Immuno Laboratories" and forward the check(s) to Immuno Laboratories immediately. If Immuno Laboratories declines acceptance of insurance assignment (e.g. non-covered service, pre-existing, policy lapse, etc.), I hereby authorize testing fees to be charged to my credit card at time of testing. Additionally, I understand Immuno Laboratories DOES NOT accept Medicare assignment as payment for its testing services.

Patient/Guardian Signature: _____

Date: _____