GeneSight® Patient Consent

By signing below, you agree to the following:

- I give consent for GeneSight testing. I understand this is a genetic test that will examine my DNA. Specifically, the GeneSight panels will test for genetic variants related to the metabolism or action of medications classified as psychotropic and for MTHFR.
- This test is intended to be used by my clinician to assist in medication treatment decision-making. By taking this test, I understand that this is not a substitute for the professional decision-making of my clinician. Any concerns I have about medication changes as a result of this test should be discussed with my clinician.
- Once my test results are provided, Myriad Neuroscience removes all personal identifiers on my sample and may use the sample and information derived from the sample for the purposes of test validation, education, and research and development of new products. Patient samples, including samples from New York, shall be destroyed at the end of the testing process or not more than 60 days after the sample collection date.
- I understand I can withdraw my consent at any time and have my sample destroyed by contacting Myriad Neuroscience at 866.757.9204.
- If I am covered by insurance, I authorize Myriad Neuroscience to give my designated insurance carrier, health plan, or third-party administrator the information necessary or reasonably requested for reimbursement. I understand Myriad Neuroscience can appeal to my health insurance plan if the service is either partially paid or denied, and release all relevant medical records, only for the purpose of health insurance plan coverage. I understand that my test may not be covered by my insurance. In that event I may receive a bill from Myriad Neuroscience.
- I authorize and direct that benefits under this claim be paid directly to Myriad Neuroscience. If I receive payment directly from my health insurance plan, I will contact Myriad Neuroscience and promptly send the payment to Myriad Neuroscience.
- I understand that $330 is an estimate of a typical patient financial responsibility for the GeneSight test. I understand that Myriad Neuroscience will contact me prior to processing my test if my total financial responsibility could be more than $330.
- I authorize Myriad Neuroscience to obtain a consumer credit report on me from a consumer reporting agency selected by Myriad Neuroscience. I understand and agree that Myriad Neuroscience may use my consumer report to confirm whether my income qualifies me for financial assistance. I understand that this inquiry will not affect my credit score.
- I agree to appoint Myriad Neuroscience to file a complaint or appeal regarding the processing or pricing of my claim to any insurer, including: CMS or their agent, any Medicare Part C plan or their agent, or any private insurer or regulatory body.
- By providing my email address and phone number below, I consent to receive secure communication from Myriad Neuroscience. I understand Myriad Neuroscience cannot guarantee the security and confidentiality of communication I may send/initiate and I am aware of the risks of communicating in this fashion. I understand that I may revoke this consent at any time by contacting Myriad Neuroscience at 866.757.9204.

I agree that I have read and understand the terms listed above. I understand that Myriad Neuroscience will send me a statement for any balance due after my health insurance plan has processed the claim. I understand and agree that I will pay the full amount of this statement to Myriad Neuroscience within 30 days of receiving the statement. If there is a balance due, I understand that Myriad Neuroscience will provide applicable patient financial assistance program information. If I qualify for financial assistance, I agree to provide Myriad Neuroscience with any additional information or documentation that may be needed to confirm my qualification for the financial assistance program.

By signing below I attest that I am the patient or someone who is designated and authorized to sign and provide consent on behalf of the patient for healthcare and financial matters. If the healthcare provider/facility allows for a verbal consent for testing (including financial responsibility), please provide in the spaces below the printed name of the authorized person giving consent and the name of the representative verifying consent. Identify each name provided.

I hereby appoint _____ as my "Personal Representative," effective on this date. This appointment shall entitle my Personal Representative to all rights pursuant to HIPAA including the right to request, receive, and review any information regarding my GeneSight test. This appointment shall remain in effect until such time as I revoke it by contacting Myriad Neuroscience at 866.757.9204.

Patient, Legal Guardian, or Other Authorized Signature _____

(signer must be 18 years or older)

Printed Name _____ Date _____

Printed Patient Name _____ Relationship to Patient _____

Email _____ Phone (mobile preferred) _____

Upon completion, fold and place this document inside the prepaid Return Envelope.
We cannot process test(s) without a signed consent form.

Customer Service 866.757.9204 • Fax 888.894.4344