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: _____

300 Goddard, Suite 100, Irvine, CA 92618 | TF: 800.710.0624 | T: 949.753.0624 | F: 949.753.1504 | www.combimatrix.com