APERIOMICS

APERIOMICS *XPLORE-PATHO*^{SM} TEST ORDER FORM

PATIENT INFORMATION AND ACKNOWLEDGEMENT:

First name:_____ Last name:_____ DOB: _____/_____/_____ Sex: ☐ Male ☐ Female

Street address:_____ City:_____ State/Province:_____ ZIP: _____ Country:_____

Cell:(_____)_____-_____ Phone:(_____)_____-_____ Email:_____

I authorize Aperiomics, Inc to test my sample(s). Aperiomics does not provide diagnosis, treatment, or medical guidance. Aperiomics provides information to be used by healthcare providers as a resource in determining their independent diagnosis and/or treatment plan. I have fully reviewed this form, understand, and agree to its terms. I understand that this test may not be covered by insurance if it falls outside of my insurance carrier's medical and coverage guidelines. I accept full financial responsibility for the pre-payment of testing as indicated on this form.

Patient's signature: _____ Date: _____/_____/_____

** Once your invoice is paid, you will receive your collection kit(s) in the mail. When Aperiomics receives your samples back, all forms must be completed in full, and your healthcare provider must have signed the requisition form and entered appropriate ICD-10 codes. Failure to have all forms completed will result in your sample(s) processing being delayed. By initialing below, I affirm that I have read and understand that I need a qualified healthcare provider to sign the requisition form for this testing service and for my samples to be processed.*

initial here: _____

PATIENT BILLING INFORMATION:

Bill Method: Credit Card: ☐ HSA/ FSA: ☐

Billing address:_____ City:_____ State/Province:_____ ZIP:_____ Country:_____

Credit Card #: _____ Exp Date:_____/_____ Security Code: _____

Name on Credit Card: _____ Signature: _____ Date:_____/_____/_____

CLINICIAN INFORMATION: *(Required for US Residents, Requested for Everyone)*

Clinic/ Clinician's Business Name: _____

Ordering Clinician's Full Name: _____ Phone: _____ Fax: _____

Email: _____ *(not required)* Clinician's Business Address: _____

City:_____ State/Province:_____ ZIP:_____ Country:_____

***XPLORE-PATHO*^{SM} COLLECTION KIT MENU:**

Blood Plasma ☐	Swab ☐ Site:_____
Fecal ☐	Urine ☐
Tissue ☐ Type:_____	Cerebral Spinal Fluid ☐
Sputum ☐	Expressed Prostate Secretion ☐

**** Please email the completed copy of this form to orders@aperiomics.com***

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Xplore-PATHO^{SM} Patient Pricing Table

	US Shipping	*International Shipping*
1 Xplore-PATHO*^{SM} *Kit Ordered	$1,000 per kit + $75 US shipping = $1,075	$1,000 per kit + $200 Int'l Shipping = $1,200
2 Xplore-PATHO*^{SM} *Kits Ordered *(10% discount)	$900 per kit + $75 US shipping = $1,875	$900 per kit + $200 Int'l Shipping = $2,000
3 or more Xplore-PATHO*^{SM} *Kits Ordered *(20% discount)	800 per kit + $75 US shipping	$800 per kit + $200 Int'l Shipping

**The 10% discount or 20% discount shown above is automatically applied when you order 2 or 3+ kits, respectively.*

# of Collection Kits Ordered: _____ US Shipping: ☐ International Shipping: ☐

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