



Comprehensive Microbial DNA Test Requisition Form

Client Information (Remember to 1. Clip nail, 2. Collect nail sample then 3. Ship to address at bottom with form)

Name: _____

Date of Birth: ____/____/____

Address: _____

Phone: _____

Occupation: _____

State/Prov _____ Country _____

M / F (Circle)

Zip _____ E-mail: _____

Where Kit was obtained: Nail Salon ___ Website ___ Other ___

Payment for the Amount: **\$199.00 USD**

Name of Facility: _____

Visa ___ MC ___ AMEX ___ Other ___ Check ___

Name of Person: _____

Credit Card # _____

Check all that applies: SSR ___ ANT ___ MNT ___

Name on Card _____

Address: _____

Exp. Date _____ CC Code _____

Signature _____

Phone: _____ E-mail: _____

(Authorizes purchase of MediNail DNA services)

Nail Specimen Source Location: (Circle one) **Sample Collection Date:** ____/____/____

SAMPLE A- RIGHT FOOT Great Toe 2nd 3rd 4th 5th

SAMPLE C- RIGHT HAND Thumb 2nd 3rd 4th 5th

SAMPLE B- LEFT FOOT Great Toe 2nd 3rd 4th 5th

SAMPLE D- LEFT HAND Thumb 2nd 3rd 4th 5th

Place sample(s) in Ziploc baggie(s) labeled A, B, C, and/or D with this form and send to:

MediNail Learning Center, OnychoTest, 1225 Taft Hwy Signal Mountain, TN 37377

Please sign/initial next to all the following statements, or your sample request will NOT be processed: IMPORTANT: The MediNail Self-Test is not intended as a substitute for medical advice provided by your physician. Please seek appropriate medical consultation and follow up care.

_____ I understand this self-test is an informational test is not to be used for diagnostic purposes. All results should be confirmed by validated clinical tests before diagnostic decisions are made. I understand that this self-test is not billable to my insurance pursuant to MediNail policies.

_____ I understand that the MediNail Self-Test and its results are not being provided pursuant to any commercial or governmental insurance carrier coverage, and that I am responsible for any and all costs associated with the Test that will be billed to the me directly and are not billable to my insurance pursuant to MediNail policies. Although I may have that option, I agree I am not billing my insurance. I understand there are no refunds for either positive or negative or inconclusive results.

_____ I understand it may take up to two (2) weeks for results or reports to become available. I agree to have MediNails, Inc. contact me with results by email or phone, or I will contact the secure portal website for my results.. You must submit your nail sample in a zip lock baggie to be processed.

_____ If I have dark linear streaking of the nail, history of melanoma, pain, or discharge, I should see a doctor immediately. I acknowledge and agree that no doctor-patient relationship is established by purchasing this test through MediNail, Inc. and that MediNail, Inc. does not provide medical treatment or advice unless additionally consulted for a separate fee. I acknowledge I reviewed the safety info before I clipped my nail and I am not injured.

Obtain Results (OPTIONS):

1. Call MediNail @ 423-805-7966 for a verbal report (by phone). (We cannot offer medical advice without a formal patient relationship.)
2. Log on to a secure website portal for results. Call 423-805-7966 or email onychotest@gmail.com for the log on information.
3. Request a faxed copy by email at onychotest@gmail.com or by faxing 423-886-1142
4. Request for a written report to your home address by email at onychotest@gmail.com