Questions about submitting your test kit, payment, or insurance? Please Call 1-855-692-6767

ACCESSION ID #

INGA

INTERGRATIVE NUTRITIONAL GENETIC ANALYSIS

Check One

☐ Patient Bill (Insurance will not pay)

☐ Specimen Type Saliva

Patient's Name (Last, First, MI) _____

Patient's Address Street _____ City _____ State _____ Zip Code _____ Country _____

SEX

Male ☐

Female ☐

Date of Birth

Month Day YR

__/__/____

Collection Date

__/__/____

Patient's Phone # _____ Patient's Email _____

TO BE COMPLETED BY ORDERING PHYSICIAN (IF ANY)

Physician's Name _____ Email_____ Phone_____

Signature_____ Date__/__/____

CREDIT CARD AUTHORIZATION

(TO BE FILLED OUT BY THE PATIENT/CARD HOLDER)
Completing this form authorizes RealTime Laboratories, Inc.(RTL) to charge the following credit card for services and/or purchases at RTL. The charge will be in U.S. dollars. I accept responsibility for payment of all charges incurred and placed on this credit card by RealTime Laboratories, INC.

Bill to Name as it appears on the credit card: (PRINTED)

_____ Phone: _____-____-_____

Patient's Name: Last_____ First_____

Credit Card: Visa / MasterCard / American Express / Discover / Health Savings Account

Number: _____ Expiration Date: _____/_____

Credit Card billing address: (PRINTED)

Address_____ Suite/Apt._____ City_____

State _____ Zip Code_____ Country _____

Test(s) are PREPAID:

☐ Integrative Nutritional Genetic Variant Nutritional Assessment Test : $250

☐ Integrative Nutritional Genetic Consultation 1 hour (Billed at Time of Consultation) : $399

Authorized Signature _____ Date __/___/__

TO BE COMPLETED BY REALTIME LAB PERSONNEL:

Date __/__/____ Personnel Initials _____ RTL Acession #_____ Notes:_____

Aug 2018