1307- A Allen Dr
Troy, MI 48083
PH#248- 846-0663
Fax#248-602-0627
Email: clientservices@vibrahealthlab.com

Acknowledgement of Self-Pay Status

Dear Patient,

You are being provided with this letter of acknowledgement because you are:

A. __________Uninsured -No Insurance Coverage

B. __________Insured - Requesting not to bill insurance

By signing below, the patient acknowledges that he/she will be receiving a $100 invoice from Vibra Hospital of Southeastern Michigan for rendering a COVID-19 PCR test.

By my signature below, I acknowledge that I have read and understood the above statement and have been given the opportunity to ask questions. I confirm that I am the patient, or the patient's duly authorized representative

Patient Name: ____________________________________ DOB: __________________________

Patient/Guardian Signature: __________________________Date: ____________________________