CENTER FOR ASSISTED REPRODUCTION EMBRYO.NET™

A Professional Association

1701 Park Place Ave.
Bedford, TX 76022
(817) 540-1157

1250 8th Ave Ste 365
Fort Worth, TX 76104
(817) 924-1572

Infertility Testing Requisition MaxTestFemale© Requisition

*Please fax to **817-267-0522** Attn: Front Office*

We will make every effort to verify benefits of the patient for MaxTestFemale©. Because AMH testing is "cutting edge" although its value is well proven, it is not covered by insurance. If patient has coverage for testing, she will be responsible for her co-pay plus the cost of AMH. If patient does not have insurance coverage for the tests, she will be responsible for paying the discounted fees.

Patient Name_____
(please print)

Patient DOB_____

Patient Contact Number_____

Patient Secondary Contact Number_____

(Please select individual test(s) or select all-inclusive **MaxTestOvary©**)

_____ TSH - $50
_____Prolactin - $50
_____Testosterone $50
_____ Day 2 or 3 FSH $50
_____ Day 2 or 3 LH $50
_____ Day 2 or 3 Estradiol $100

_____ AMH ($115 not billable to insurance)
_____ Sonogram (ovarian volume /antral follicle count) - $125

_____ All-inclusive **MaxTestOvary©** - $400

(Please select individual test(s) or select all-inclusive **MaxTestAnatomical©**)

_____ Hysterosalpingogram - $525
_____ Diagnostic Hysteroscopy - $600

_____ Comprehensive (2D/3D) Pelvic Ultrasound - $200
_____ All-inclusive **MaxTestAnatomical©** - $800

Diagnosis (Please select one):
_____ Infertility
_____ Procreative Management

_____ Other _____

Choose location:
_____ Bedford

Referring Physician (Print) _____ Referring Physician Signature_____

Patient signature_____

*If ordering all three **MaxTests©** **[MaxTestOvary©, MaxTestAnatomical©** (next page) **and MaxTestMale©],** a discount applies. The discounted fee will be **$1,500 total** for patients without insurance. Prepayment is required.*
To expedite the scheduling process, please also fax a demographic sheet and insurance information for the patient.
**All fees are subject to change at any time without notice.*
**Borderline laboratory tests will be repeated at no charge.*

_____ I would like a CARE physician to call the patient to discuss results.

_____ I prefer to discuss the test results with the patient. Please do not call them

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(817) 924-1572

10840 Texas Health Trl Ste. 210
Fort Worth, TX 76244
(817) 540-1157

MaxTestMale© Requisition
*Please fax to **817-267-0522** Attn: Front Office*
MaxTest Male© will not be filed to insurance. Patients are responsible for the discounted payment prior to testing.

Patient Name_____
(please print)
Patient DOB_____

Patient Contact Number_____

Patient Secondary Contact Number_____

(Please select individual test(s) or select all-inclusive **MaxTestMale©**)

_____ Morphology (strict) with semen analysis - $150
_____ Comprehensive computer assisted semen analysis (CASA) - $75
_____ Endocrine Panel: Testosterone, TSH, Prolactin, LH and FSH - $250
_____ Direct sperm antibody test with semen analysis - $150
_____ DNA Fragmentation (Index) with semen analysis – $200

_____ All-inclusive **MaxTestMale©** - $500

Diagnosis (Please select one):

_____ Infertility _____ Procreative Management

_____ Other _____

Choose location:
_____ Bedford

Referring Physician (Print) _____ Referring Physician Signature_____

Patient signature_____

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