BAYLOR GENETICS

BAYLOR GENETICS
2450 HOLCOMBE BLVD.
SUITE 2210
HOUSTON, TX 77021-2024

PHONE
1.800.411.4363
FAX
1.800.434.9850

CONNECT

GENOME REANALYSIS REQUISITION

PATIENT INFORMATION (COMPLETE ONE FORM FOR EACH PERSON TESTED)

Patient Last Name | Patient First Name | MI | Date of Birth (MM / DD / YYYY)

Address | City | State | Zip | Phone

Accession # | BG Lab #

Hospital / Medical Record # | BG Family #

Genetic Sex:
◯ Female ◯ Male ◯ Unknown
Gender identity (if different from above):

ORDERING PHYSICIAN

Ordering Physician*

Institution Name

Email (Required for International Clients)

Phone | Fax

(If different from original order, complete Request for and Consent to Release Information from Individual's Records, pg. 2)

ADDITIONAL REPORTS

Name | Email | Phone | Fax

Name | Email | Phone | Fax

Note: Reports will be sent by FAX except for international recipients

PAYMENT (FILL OUT ONE OF THE OPTIONS BELOW)

◯ **SELF PAYMENT**

☐ Pay With Sample ☐ Bill To Patient

◯ **INSTITUTIONAL BILLING**

Institution Name | Institution Code | Institution Contact Name | Institution Phone | Institution Contact Email

◯ **INSURANCE**

☐ Do Not Perform Test Until Patient is Aware of Out-Of-Pocket Costs (excludes prenatal testing)

REQUIRED ITEMS 1. Copy of the Front/Back of Insurance Card(s) 2. ICD10 Diagnosis Code(s) 3. Name of Ordering Physician 4. Insured Signature of Authorization

Name of Insured | Insured Date of Birth (MM / DD / YYYY)

Patient's Relationship to Insured | Phone of Insured

Address of Insured

City | State | Zip

Primary Insurance Co. Name | Primary Insurance Co. Phone

Primary Member Policy # | Primary Member Group #

Name of Insured | Insured Date of Birth (MM / DD / YYYY)

Patient's Relationship to Insured | Phone of Insured

Address of Insured

City | State | Zip

Secondary Insurance Co. Name | Secondary Insurance Co. Phone

Secondary Member Policy # | Secondary Member Group #

By signing below, I hereby authorize Baylor Genetics to provide my insurance carrier any information necessary, including test results, for processing my insurance claim. I understand that I am responsible for any co-pay, co-insurance, and unmet deductible that the insurance policy dictates, as well as any amounts not paid by my insurance carrier for reasons including, but not limited to, non-covered and non-authorized services. I understand that I am responsible for sending Baylor Genetics any and all payments that I receive directly from my insurance company in payment for this test. Please note that Medicare does not cover routine screening tests.

Patient's Printed Name | Patient's Signature | Date (MM / DD / YYYY)

STATEMENT OF MEDICAL NECESSITY (REQUIRED)

This requisition hereby incorporates the Terms and Conditions of the Laboratory Services found at https://www.baylorgenetics.com/lab-terms-conditions/ or, in the case of international entities https://www.baylorgenetics.com/terms-conditions-of-the-laboratory-services-international/. This test is medically necessary for the risk assessment, diagnosis, or detection of a disease, illness, impairment, symptom, syndrome, or disorder. The results will determine my patient's medical management and treatment decisions. The person listed as the Ordering Physician is authorized by law to order the test(s) requested herein. I confirm that I have provided genetic testing information to the patient and they have consented to genetic testing.

Physician's Printed Name | Physician's Signature | Date (MM / DD / YYYY)

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REQUEST FOR AND CONSENT TO RELEASE OF INFORMATION FROM INDIVIDUAL'S RECORDS

Please complete if reanalysis is being requested by a different provider than original ordered genome.

BACKGROUND INFORMATION

NOTE: The execution of this form does not authorize the release of information other than that specifically described below. This form authorizes the release of information that you specify in accordance with 5 U.S.C., Section 5701 and 7332; and 45 C.F.R., parts 160 and 164.

Individual/Patient Last Name | Individual/Patient First Name | MI | Date of Birth (MM / DD / YYYY)

BG Lab # | BG Family # | Ordering Physician Phone | Ordering Physician Fax

Individual or Organization's Name to Whom Information is Being Released

Address | City | State | Zip

Information Requested:

Purpose(s) or need for which information is to be used by Organization of Individual to whom information is to be released:

I want my original provider to receive the results of the analysis: ◯ Yes ◯ No

AUTHORIZATION AND CERTIFICATION

I certify that this request has been made freely, voluntarily, and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand this release may not be obtained or offered as condition for treatment, payment, or other eligibility for benefits upon my signing this authorization. I may revoke this authorization at any time in writing, except to the extent that this action has already been taken to comply with it. Written revocation is effective upon receipt by the facility housing the records. Upon release, my records will no longer be protected, and re-disclosure by those receiving the information may be accomplished without my further authorization. Without my express revocation, the authorization will automatically expire upon satisfaction of the need for disclosure, under the conditions listed below, or upon this date _____ (supplied by individual/patient).

Individual/Patient Signature | Date (MM / DD / YYYY)

Personal Representative Signature, if not signed by patient* | Date (MM / DD / YYYY)

*[NOTE: ATTACH DOCUMENTS DEMONSTRATING YOUR AUTHORITY TO ACT ON BEHALF OF THE PATIENT.]
PLEASE FAX COMPLETED FORM TO: 713.798.2787

OP.FR 6 Authorization For Release of Protected Health Information

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GENOME REANALYSIS REQUISITION

Patient Last Name | Patient First Name | MI | Date of Birth (MM / DD / YYYY) | Genetic Sex

GENOME REANALYSIS TEST OPTIONS

☐ 1897 Genome Reanalysis

PHENOTYPE INFORMATION (REQUIRED)

◯ **YES** Phenotype has changed and I have included an updated clinical note and/or other documentation. (Please complete the "Indication for Testing" section.)

◯ **NO** Phenotype has NOT changed. I have reviewed the phenotype information included in the clinical summary section of the WGS report and I agree this is currently accurate information.

OPT-IN TESTING OPTIONS

Opt-in for RNA Sequencing (RNASeq) as reflex to genome reanalysis

☐ If Genome Reanalysis identifies a qualified variant that might be reclassified through RNA Sequencing, please notify me about this variant. A new blood sample will need to be collected from this patient to perform RNAseq.

INDICATION FOR TESTING (REQUIRED IF SELECTED "YES" FOR THE "PHENOTYPE INFORMATION" SECTION.)

Please provide the following clinical information regarding the patient to be tested. Please also submit a clinic note and pedigree, if available. Phenotypes listed are in HPO terms with the corresponding HPO number (http://human-phenotype-ontology.github.io/). This information is needed to facilitate interpretation of whole genome sequencing results. If the laboratory requires additional information, please indicate the health care provider to be contacted:

Physician Name | Physician Phone | ICD-10 Diagnosis Code(s)

PRE/PERINATAL HISTORY

- ☐ 0001622 Prematurity - GA at birth _____
- ☐ 0001511 Intrauterine Growth Restrictions
- ☐ 0001562 Oligohydramnios
- ☐ 0001561 Polyhydramnios
- ☐ 0000476 Cystic Hygroma
- ☐ 0000776 Congenital Diaphragmatic Hernia
- ☐ 0001508 Failure to Thrive
- ☐ 0001539 Omphalocele
- ☐ 0002084 Encephalocele
- ☐ 0010880 Increased Nuchal Translucency
- ☐ _____

EYE DEFECTS & VISION

- ☐ 0000505 Visual Impairment
- ☐ 0000618 Blindness
- ☐ 0000589 Coloboma
- ☐ 0000526 Aniridia
- ☐ 0000528 Anophthalmia
- ☐ 0000568 Microphthalmia
- ☐ 0000508 Ptosis
- ☐ 0000486 Strabismus
- ☐ 0000519 Cataract Congenital Bilateral
- ☐ _____
- ☐ _____

MOTOR/COGNITIVE DEVELOPMENT

- ☐ 0000750 Delayed Speech & Language Development
- ☐ 0001270 Delayed Motor Milestones
- ☐ 0002376 Developmental Regression
- ☐ Intellectual Disability
  - ☐ 0001256 Mild
  - ☐ 0002342 Moderate
  - ☐ 0010864 Severe
- ☐ 0000729 Autistic Spectrum Disorder
- ☐ _____
- ☐ _____

STRUCTURAL BRAIN ABNORMALITIES

- ☐ 0001360 Holoprosencephaly
- ☐ 0001339 Lissencephaly
- ☐ 0002084 Encephalocele
- ☐ 0000238 Hydrocephalus
- ☐ 0002119 Ventriculomegaly
- ☐ 0001273 Abnormality of Corpus Callosum
- ☐ 0002539 Cortical Dysplasia
- ☐ 0012444 Brain Atrophy
- ☐ 0002352 Leukoencephalopathy
- ☐ 0002269 Abnormality of Neuronal Migration
- ☐ 0002126 Polymicrogyria
- ☐ 0001302 Pachgyria
- ☐ 0002500 Abnormality of Cerebral White Matter
- ☐ 0007266 Cerebral Dysmyelination
- ☐ 0006808 Cerebral Hypomyelination
- ☐ 0002134 Abnormality of the Basal Ganglia
- ☐ 0002363 Abnormality of the Brainstem
- ☐ 0007360 Aplasia/Hypoplasia of the Cerebellum
- ☐ 0006817 Aplasia/Hypoplasia of the Cerebellar Vermis
- ☐ _____

NEUROLOGICAL

- ☐ 0001284 Areflexia
- ☐ 0200134 Epileptic Encephalopathy
- ☐ 0001250 Seizures
  - ☐ 0002373 Febrile Seizures
  - ☐ 0012469 Infantile Spasms
  - ☐ 0002123 Generalized Myoclonic Seizures
  - ☐ 0002069 Generalized Tonic-clonic Seizures
  - ☐ 0010818 Generalized Tonic Seizures
  - ☐ 0010819 Atonic Seizures
  - ☐ 0002121 Absence Seizures
  - ☐ 0011169 Generalized Clonic Seizures
  - ☐ 0001251 Ataxia
  - ☐ 0001332 Dystonia
  - ☐ 0002072 Chorea
  - ☐ 0001257 Spasticity
  - ☐ 0009830 Neuropathy
- ☐ _____
- ☐ _____

CRANIOFACIAL

- ☐ 0000256 Macrocephaly
- ☐ 0000252 Microcephaly
- ☐ 0001363 Craniosynostosis
- ☐ 0000204 Cleft Upper Lip
- ☐ 0000175 Cleft Palate
- ☐ 0000316 Hypertelorism
- ☐ 0000601 Hypotelorism
- ☐ 0008050 Abnormality of the Palpebral Fissures
- ☐ 0000286 Epicanthal Folds
- ☐ 0000288 Abnormality of the Philtrum
- ☐ 0010938 Abnormality of the External Nose
- ☐ _____
- ☐ _____

Indications continued on next page

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GENOME REANALYSIS REQUISITION

Patient Last Name | Patient First Name | MI | Date of Birth (MM / DD / YYYY) | Genetic Sex

INDICATION FOR TESTING (REQUIRED) - CONTINUED

HAIR & SKIN

- ☐ 0000957 Cafe-Au-Lait Spots
- ☐ 0001034 Hypermelanotic Macule
- ☐ 0001010 Hypopigmentation of the Skin
- ☐ 0008066 Abnormal Blistering of the Skin
- ☐ 0008064 Ichthyosis
- ☐ 0000988 Skin Rash
- ☐ 0001581 Recurrent Skin Infections
- ☐ 0005306 Capillary Hemangiomas
- ☐ 0001597 Abnormality of the Nail
- ☐ 0004554 Generalized Hypertrichosis
- ☐ 0001596 Alopecia
- ☐ 0002208 Coarse Hair
- ☐ 0002299 Brittle Hair
- ☐ _____
- ☐ _____

CARDIAC

- ☐ 0001631 Atria Septal Defect
- ☐ 0001629 Ventricular Septal Defect
- ☐ 0001655 Patent Foramen Ovale
- ☐ 0001713 Abnormality of Cardiac Ventricle
- ☐ 0001636 Tetralogy of Fallot
- ☐ 0001680 Coarctation of Aorta
- ☐ 0001647 Bicuspid Aortic Valve
- ☐ 0002616 Aortic Root Dilatation
- ☐ 0001638 Cardiomyopathy
- ☐ 0011675 Arrhythmia
- ☐ _____
- ☐ _____

GENITOURINARY

- ☐ 0000113 Polycystic Kidney Dysplasia
- ☐ 0000107 Renal Cyst
- ☐ 0008738 Partially Duplicated Kidney
- ☐ 0000104 Renal Agenesis
- ☐ 0000085 Horseshoe Kidney
- ☐ 0000069 Abnormality of the Ureter
- ☐ 0000795 Abnormality of the Urethra
- ☐ 0000047 Hypospadias
- ☐ 0000028 Cryptorchidism
- ☐ 0000035 Abnormality of the Testis
- ☐ 0000062 Ambiguous Genitalia
- ☐ _____
- ☐ _____

RESPIRATORY

- ☐ 0002093 Respiratory Insufficiency
- ☐ 0002878 Respiratory Failure
- ☐ 0002104 Apnea
- ☐ 0002791 Hypoventilation
- ☐ 0002883 Hyperventilation
- ☐ 0002788 Recurrent Upper Respiratory Tract Infections
- ☐ _____
- ☐ _____

METABOLIC

- ☐ 0001946 Ketosis
- ☐ 0003074 Hyperglycemia
- ☐ 0001943 Hypoglycemia
- ☐ 0001941 Acidosis
- ☐ 0003128 Lactic Acidosis
- ☐ 0003215 Dicarboxylic Aciduria
- ☐ 0002490 Increased CSF lactate
- ☐ 0001992 Organic Aciduria
- ☐ 0030085 Abnormal CSF Lactate Level
- ☐ 00003542 Increased Serum Pyruvate
- ☐ 0003535 3-Methylglutaconic aciduria
- ☐ 0001942 Metabolic acidosis
- ☐ 0100493 Hypoammonemia
- ☐ 0001987 Hyperammonemia
- ☐ 0004923 Hyperphenylalaninemia
- ☐ 0003234 Decreased Plasma Carnitine
- ☐ 0003236 Elevated Serum Creatine Phosphokinase
- ☐ Abnormal Newborn Screen
- ☐ Unusual Color/Odor
- ☐ _____
- ☐ _____

MUSCULOSKELETAL

- ☐ 0011398 Hypotonia
- ☐ 0001276 Hypertonia
- ☐ 0000098 Tall Stature
- ☐ 0004322 Short Stature
- ☐ 0001382 Joint Hypermobility
- ☐ 0001371 Flexion Contracture
- ☐ 0002804 Arthrogryposis Multiplex Congenita
- ☐ 0001161 Hand Polydactly
- ☐ 0001829 Foot Polydactly
- ☐ 0006101 Finger Syndactly
- ☐ 0001770 Toe Syndactly
- ☐ 0100490 Camptodactyly of Finger
- ☐ 0012165 Oligodactyly
- ☐ 0001762 Talipes Equinovarus
- ☐ 0002757 Recurrent Fractures
- ☐ 0002650 Scoliosis
- ☐ 0002808 Kyphosis
- ☐ 0003307 Hyperlordosis
- ☐ 0001528 Hemihypertrophy
- ☐ 0001513 Obesity
- ☐ 0001548 Overgrowth
- ☐ 0002652 Skeletal Dysplasia
- ☐ _____
- ☐ _____

GASTROINTESTINAL

- ☐ 0002021 Pyloric Stenosis
- ☐ 0002575 Tracheoesophogeal Fistula
- ☐ 0002032 Esophageal Atresia
- ☐ 0002020 Gastroesophageal Reflux
- ☐ 0001733 Pancreatitis
- ☐ 0002014 Diarrhea
- ☐ 0002019 Constipation
- ☐ 0002037 Inflammatory Bowel Disease
- ☐ 0004389 Intestinal Pseudo-Obstruction
- ☐ 0001399 Hepatic Failure
- ☐ 0002572 Episodic Vomiting
- ☐ 0001744 Splenomegaly
- ☐ 0002240 Hepatomegaly
- ☐ 0001508 Postnatal Failure to Thrive
- ☐ 0002578 Gastroparesis
- ☐ _____
- ☐ _____

Indications continued on next page

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GENOME REANALYSIS REQUISITION

Patient Last Name | Patient First Name | MI | Date of Birth (MM / DD / YYYY) | Genetic Sex

INDICATION FOR TESTING (REQUIRED) - CONTINUED

ENDOCRINE

- ☐ 0000819 Diabetes Mellitus
- ☐ 0000873 Diabetes Insipidus
- ☐ 0000821 Hypothyroidism
- ☐ 0000829 Hypoparathyroidism
- ☐ 0000834 Abnormality of the Adrenal Glands
- ☐ 0001738 Exocrine Pancreatic Insufficiency
- ☐ 0002721 Immunodeficiency
- ☐ _____
- ☐ _____

EAR DEFECTS & HEARING

- ☐ 0000407 Sensorineural Hearing Impairment
  - ☐ 0008619 Bilateral
- ☐ 0000405 Conductive Hearing Impairment
- ☐ 0000410 Mixed Hearing Impairment
- ☐ 0004467 Preauricular Pit
- ☐ 0000384 Preauricular Skin Tag
- ☐ 0000369 Low-set Ears
- ☐ 000037 Abnormality of the Pinna
- ☐ _____
- ☐ _____

HEMATOLOGY

- ☐ 0001875 Neutropenia
  - ☐ 0005549 Congenital
  - ☐ Chronic
  - ☐ Cyclic
- ☐ 0001873 Thrombocytopenia
- ☐ 0040185 Macrothrombocytopenia
- ☐ 0005537 Decreased Mean Platelet Volume
- ☐ 0005518 Erythrocyte Macrocytosis
- ☐ 0004444 Spherocytosis
- ☐ 0012410 Pure Red Cell Aplasia
  - ☐ Aplastic
  - ☐ Hypoplastic
- ☐ 0001903 Anemia
- ☐ 0005528 Bone Marrow Hypocellularity
- ☐ _____
- ☐ _____

CANCER

- ☐ Type of Cancer _____
- ☐ Age of Diagnosis _____
- ☐ Family History of Cancer and Affected Relatives

_____

_____

OTHER

- ☐ Organomegaly
- ☐ Chronic Infections
- ☐ 0004311 Abnormality of Macrophages
- ☐ 0001954 Episodic Fever
- ☐ 0004313 Hypogammaglobulinemia
- ☐ 0010701 Abnormal Immunoglobulins
- ☐ 0002721 Immunodeficiency
- ☐ 0012088 Abnormal urinary odor
- ☐ 0012537 Food intolerance
- ☐ 0008067 Abnormally lax or hyperextensible skin
- ☐ Abnormal Movements
- ☐ Family History of Similar Disorder
- ☐ 0001254 Lethargy
- ☐ 0002415 Leukodystrophy
- ☐ _____
- ☐ _____

GENES OF INTEREST

_____

_____

_____

_____

ADDITIONAL CLINICAL INFORMATION

DIFFERENTIAL DIAGNOSIS

Consent on next page

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INFORMED CONSENT FOR GENOME REANALYSIS TESTING

Patient Last Name	Patient First Name	MI	Date of Birth (MM / DD / YYYY)	Genetic Sex
			/ /	

WHOLE EXOME SEQUENCING (WES) AND WHOLE GENOME SEQUENCING (WGS) CONSENT

This consent form can only be used for whole exome sequencing and whole genome sequencing. Consent forms for other tests are located at Baylor Genetics' website (https://www.baylorgenetics.com/consent/).

For the purposes of this consent, "I", "my", "you", and "your" can refer to you, your child, your unborn child, or other individual you are the legal representative of.

TEST INFORMATION

Your healthcare provider (doctor, genetic counselor, or other person with medical training) wants to order a genetic test called Whole Genome Sequencing (WGS) or Whole Exome Sequencing (WES). These tests look for changes, called variants, in a person's DNA that can cause health issues. DNA is our genetic material. These variants can be in certain genes, specific parts of our DNA that are needed for our health. They can also be found in other places in the genome (all DNA that a person has). Based on your known health issues, variants in your DNA that may cause these issues will be reported. This test may explain your health issues. It may also explain health issues that your family may have. Even if this test finds the cause of your health issues, this may not help treat or manage those issues.

Testing where your DNA is compared to one or more family members may be performed. This may help better understand your results or show if your family members have the same variant as you.

Before you sign this consent form, you should speak with your healthcare provider. They can help you understand this testing and what it means for your health.

TEST RESULTS

There are several types of test results that may be reported including:

- **Positive:** A variant in the DNA was found that is related to your health issues or a health issue that you are at an increased risk of having in the future. These changes that cause disease are also known as pathogenic variants.
- **Negative:** No variants in the DNA were found that are related to your health issues or that would increase your risk of a health issue in the future.
- **Variant of Uncertain Clinical Significance (VUS):** A variant in the DNA was found that we do not know its effect, if any, on health. More testing may be needed for you or your family if a VUS is found that may be associated with your health issues.
- **Secondary and Incidental Findings (Optional):** Testing can sometimes find a variant in the DNA not related to the reason for testing but can change your medical care. **Note:** Certain issues within the brain start in adulthood and get worse over time (neurodegenerative). They often have no cure or treatment. By default, these variants will not be reported unless they are related to your health issues. However, variants in one or more of these gene(s) can be requested if needed. Your provider must write each gene needed in your test order.
- **Genes of No Known Disease Association (Optional):** Testing may find a variant in a gene that is not known to cause disease. This may be helpful to learn more about these genes in the future. These results do not currently impact medical management or indicate a diagnosis.

SECONDARY AND INCIDENTAL FINDINGS

The following categories of variants are not expected to cause your current health issues. However, they can each be requested to be reported. Knowing about these variants might affect your future medical care.

- **ACMG Secondary Findings:** The American College of Medical Genetics and Genomics (ACMG) recommends reporting disease-causing variants in certain genes that cause health issues. Each family member can request this group of variants to be reported.
- **Incidental Findings:** Other variants known to cause health issues but that are not causing your current health issues.

CONSIDERATIONS AND LIMITATIONS

- You should speak with your provider before signing this consent form to understand the risks, benefits, and alternatives to testing.
- Testing may show you have, or are at increased chance of having, a health issue. It may show that you have an increased chance of having a child with a health issue.
- Even if the variant(s) causing your health issues are found, how these issues might progress or improve with treatment might not be known. Affected family members with the same variant might not be affected like you are.
- Depending on the results of testing, more testing may be needed to understand these results. This testing might be needed for you and/or other family members.
- A negative result does not rule out the chance for health issues. Our knowledge of variants and how they cause disease may change over time as we learn more about genetics. Testing has limitations to what it can find as well.
- Certain factors may lead to incorrect results. These include mislabeled samples, incorrect information in the test order, and rare technical errors.
- More sample may be needed from you if the first sample is not sufficient to complete testing.

FOR SAMPLES FROM NEW YORK STATE RESIDENTS

Samples from New York State residents shall not be included in research without written consent. Samples will not be retained for more than sixty (60) days after receipt by Baylor Genetics, unless authorized by marking below. No tests other than those authorized shall be performed on the samples.

☐ I authorize Baylor Genetics to retain sample(s) longer based on our retention policy for test development, quality assurance, and training purposes.

PATIENT CONFIDENTIALITY AND SAMPLE RETENTION

- If several family members are tested, knowing the correct biological relationships among them is important. In rare cases, testing can show that family members are not related as expected. If this is found, we may contact the provider who ordered your testing.
- If this testing is requested to be cancelled after the order and sample are sent to the laboratory, please see our Test Cancellation Policy at www.baylorgenetics.com/cancel-test/.

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INFORMED CONSENT FOR GENOME REANALYSIS TESTING

Patient Last Name | Patient First Name | MI | Date of Birth (MM / DD / YYYY) | Genetic Sex

PATIENT CONFIDENTIALITY AND SAMPLE RETENTION (CONTINUED)

- Only Baylor Genetics and its contracted partners will have access to your sample for the ordered testing. Results from testing will only be released to: (i) a licensed healthcare provider, (ii) those authorized in writing, (iii) the patient or their personal representative, and (iv) those allowed access to test results by law. You have the right to access your test results from Baylor Genetics by providing a written request. You also have the right to request raw data obtained from your sample by providing a written request or HIPAA Authorization Form.
- In rare cases, people with genetic diseases may have problems with health insurance and employment. The U.S. Federal Government has several laws that prohibit discrimination based on test results by health insurance companies and employers. These laws also prohibit unauthorized disclosure of this information. For more information, please visit www.genome.gov/10002077.
- Samples will be kept in the laboratory based on our retention policy. Once testing is completed, the de-identified sample may be used for test development, quality assurance, and training purposes. Samples are not returned to patients or providers unless requested prior to testing. You and your heirs will not receive payments, benefits, or rights to any resulting products or discoveries.
- The information from your testing may be used in scientific research, publications or presentations, but your specific identity will not be revealed. We may contact your provider to obtain more clinical information about you. Baylor Genetics also performs other types of scientific research and may contact you to see if you would like to be involved.
- Variants found may be submitted to databases. The medical community uses these databases to collect information about how variants might cause disease to improve testing and treatment for patients. An example is ClinVar, a free, public archive of reports on human genetics. Limited clinical information may need to be shared with these databases. In rare cases, this information may be enough to allow you or your family members to be identified.
- For more information on privacy practices at Baylor Genetics, please visit www.baylorgenetics.com/privacy-practices/.

FINANCIAL AGREEMENT

By signing below, I hereby authorize Baylor Genetics to provide my insurance carrier any information necessary, including test results, for processing my insurance claim. I understand that I am responsible for any co-pay, co-insurance, and unmet deductible that the insurance policy dictates. I designate Baylor Genetics as my designated representative for purposes of appealing any denial of benefits by my insurance carrier. I irrevocably assign associated payment to Baylor Genetics, and direct that payment be made directly to Baylor Genetics. Please note, some payers may not cover certain screening tests.

If my health insurer does not cover the test or I do not have health insurance, I have received a good faith estimate of the cost for the genetic testing ordered by my provider and agree to pay for the cost of the genetic testing billed to me by Baylor Genetics based on that good faith estimate. More information is available in Baylor Genetics' No Surprises Act and Good Faith Estimate Notice located at https://www.baylorgenetics.com/no-surprises-act/.

A Medicare Advance Beneficiary Notice (ABN) is required for services Medicare identifies as not medically necessary.

PATIENT AUTHORIZATION

By signing this statement of consent, I acknowledge that I have read, understand, and hereby grant my informed consent for genetic testing. I have received appropriate explanations from my healthcare provider about the planned genetic test(s) and possible results. I have been informed by my healthcare provider about the availability and importance of genetic counseling and have been provided with written information identifying a genetic counselor or medical geneticist who can provide such counseling services. All my questions have been answered, and I have had the necessary time to make an informed decision about the genetic test(s).

Note: If Prenatal WES was ordered, please leave the Patient section blank and complete only a section for each relative tested below.

I hereby give permission to Baylor Genetics to conduct genetic testing as recommended by my healthcare provider.*

Patient Name | Patient Signature | Date Signed (MM / DD / YYYY)

Relationship to Patient	Name	Signature	Date
Relative 1			
Relative 2			
Relative 3			

If one or more family members have a Representative signing on their behalf:

Name | Signature | Date (MM / DD / YYYY) | Representative For | Relationship to Represented Person(s)

*If you are signing on behalf of the patient as the parent(s) and/or person with legal authority to act on behalf of the patient or parent, you may be required to provide evidence of your authority.

FOR SURROGATES PREGNANCIES – FOR PRENATAL WES ONLY:

Maternal cell contamination (MCC) studies use blood or another sample from a pregnant person. MCC studies are used to determine that the sample being tested belongs to the fetus and not the pregnant person. The results of MCC studies are not used for the treatment or management of the fetus, pregnant person, or other individuals, and are not part of the pregnant person's designated medical record.

I hereby give permission for my sample to be used for MCC studies:

Surrogate Name | Surrogate Signature | Date Signed (MM / DD / YYYY)