CARING FOR WOMEN, P.C.
Pap Smear Consent Form

If your insurance requires that you use a specific lab, be sure to let us know each time.

Please send my pap to my insurance preferred lab which is: Quest ___________
Lab Corp________
Ak. Regional Lab ________
Prov. Hosp. ________

****In the event of an abnormal pap result, further testing may be ordered from the same pap sampling. There may be an additional cost to you for the test.**

___________________ I agree to further testing if my pap results are abnormal.

Patient Signature ____**Date** ____________________