Patient Registration Form

Name:______________________ ☐ Male ☐ Female

DOB: ______________________

Mailing Address:______________________ Apt #:________

City, State, Zip:______________________

Mobile Phone: ______________________

Personal Email: ______________________

Primary Care Physician (PCP): ______________________

Preferred Pharmacy: ______________________

Address: ______________________

City/State/Zip: ______________________

Best Form of Contact: ☐ Mobile ☐ Email ☐ Mail ____________

Best Time to Call:____________ May we leave a message? ☐ Yes ☐ No

Race

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ White
☐ Hispanic or Latino
☐ Declined to Specify
Other

In order for us to service your account or collect any amounts owed to us, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which may result in additional charges from your phone carrier. We may also contact you by sending an email using the email address you have provided.

and agree that you may contact me as described above. ________

PLEASE INITIAL

Emergency Contact

This person will be contacted in emergencies and allowed to receive information about your medical treatment.

Name: ______________________ ☐ Male ☐ Female

Relationship:____________ Mobile Phone____________

Financial Responsibility

☐ Check if same as patient information. If not, please complete the entire section.

Name: ______________________ ☐ Male ☐ Female

Relationship: ______________________

DOB:______________________

Phone: ______________________

Insurance Information

☐ Check if same as patient information. If not, please complete the entire section.

Primary Insurance: ______________________

Subscriber #: ______________________

Subscriber Name: ______________________

DOB:____________ Relationship: ____________

Secondary Insurance: ______________________

Subscriber #: ______________________

Subscriber Name: ______________________

DOB:____________ Relationship: ____________

Patient Registration Form

Consent for Treatment/Acknowledgement of Privacy Practices/Acknowledgement of Financial Responsibility

I, the undersigned, consent to the care and treatment by the attending Physician, his/her associates or assistants and acknowledge that no guarantees have been made as to the effect of such treatment.

I have reviewed the Notice of Privacy Practices as provided at registration and understand that I may request a copy of the policy at any time.

I acknowledge full financial responsibility to any services received and I understand that the payment of charges incurred in this office is due at the time of service. I also understand that the charges not covered by insurance remain my responsibility. In the event that my account is turned over to a collection agency, I agree to pay all late fees, costs of collection fees and/or Attorney's fees and all court costs, if any. I understand that any services not provided directly by Lab Testing Near Me, LLC (Lab results, diagnostic services) are a separate charge and those charges will be billed separately by the provider of such services.

______________________________ ______________________________

Signature (Patient/Guardian) *Date:*

Assignment of Benefits

I agree, whether by signing as legally authorized representative of the patient or as the patient to authorize and direct all insurance companies under which I am insured to directly pay Lab Testing Near Me, LLC all benefits due under said policies for all services rendered. I hereby irrevocably assign and transfer to Lab Testing Near Me, LLC all the rights, title and interest in the benefits payable for serv ices provided as delineated in any insurance policy or health benefit plan under which I am covered.

______________________________ ______________________________

Signature (Patient/Guardian) *Date:*

PRE-SCREENING QUESTIONNAIRE

Is this you first COVID-19 Test?	YES	NO
Are you a healthcare worker?	YES	NO
Have you been hospitalized for COVID-19 in the last 30 days?	YES	NO
If yes, where?________________________________		
Are you pregnant?	YES	NO
Have you been exposed to anyone with COVID-19	YES	NO

IN THE LAST 48 HOURS:

Have you had a fever (99.5 or higher)?	YES	NO

HAVE YOU EXPERIENCED ANY:

Coughing?	YES	NO
Sore Throat?	YES	NO
Difficulty Breathing?	YES	NO
Muscle Aches?	YES	NO
Stomach Pain?	YES	NO
Loss in Taste/Smell	YES	NO

PATIENT NAME:____

PATIENT SIGNATURE:____

DATE:____

Please read/check the following carefully:

- This test is currently under an FDA EUA (Emergency Use Authorization)
- This test is under an FDA approved EUA for COVID-19 testing. This lab is approved by The Centers for Medicare & Medicaid Services (CMS) that regulates all laboratory testing performed on humans in the U.S. through the Clinical Laboratory Improvement Amendments (CLIA)
- This diagnostic test is a nasal swab collection for the detection of the proteins/pieces of SARS-CoV-2 that makes the pieces or causes COVID-19
- If you have tested positive, it is very likely that you have COVID-19 due detection of proteins/pieces of SARS-CoV-2 were found in your sample.
- A negative test means that there were no detection of proteins/pieces of SARS-CoV-2 in your sample and you were negative only at time of test. However, a negative test does not rule out COVID-19 or mean you will not get sick.
- If I have symptoms for COVID-19, I will let a Lab Testing Near Me staff member know, and they will guide me with the next appropriate steps.
- I have read and understand the above-mentioned information regarding the Covid-19 testing.

Print Name: ______________________________

Patient Signature: ______________________________

Date: ______________________________

PERMISSION TO USE PROTECTED HEALTH INFORMATION

I acknowledge that I have the right to revoke or further restrict this authorization in writing, at any time. I also understand that a revocation may not be effective if any entity or individual has already acted in reliance on my prior authorization. I will not be able to revoke my authorization if I have previously given authorization as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that I have the right to limit who can access my private health information. I authorize Lab Testing Near Me, LLC to share my private health information with any of the individuals I have listed below. The designated individuals to whom I grant access to my medical records include:

Name:______________________________________ Relationship:______________________________________

Phone:______________________________________ Email:______________________________________

Name:______________________________________ Relationship:______________________________________

Phone:______________________________________ Email:______________________________________

Primary Care Physician:____

Do you grant us permission to fax, email, or mail a copy of medical records from your visit? ○ YES ○ NO

I authorize Lab Testing Near Me, LLC to send text messages that might contain PHI to my cell phone or via email to my email address to convey medical information regarding billing, and/or statements and other important patient account information. I understand that standard text messaging rates will apply to any messages received from Lab Testing Near Me. I understand that any PHI received via text messaging or via email is unencrypted data and the modes of communication involve a level of risk that the PHI may be read by an unauthorized third party. I fully understand, acknowledge and accept the risks associated with PHI being transmitted via text messaging and/or email, and I waive any legal recourse against Lab Testing Near Me. I also understand that I, or Lab Testing Near Me, may revoke this permission in writing at any time. I agree not to hold Lab Testing Near Me or my associated provider liable for any electronic messaging charges or fees generated by this service. I understand that Lab Testing Near Me will not use my PHI for unauthorized purposes and it will not be shared with any person or organization without my consent. I further agree that in the event my cell phone number and or cell provider changes I will inform Lab Testing Near Me. I understand the foregoing disclosure provided to me involving the transmission of my PHI using text messaging and/or email, along with the risks of my PHI being ascertained by unauthorized third parties, and I agree to waive any actions, claims, suits, causes of actions or administrative proceedings against Lab Testing Near Me.

I understand that my treatment will not be conditioned on whether I sign this authorization.

____ ________________________

Patient Signature / Responsible Adult Date

Relationship to patient ________________________________ and I have signed this consent on his/her behalf.

SARS-CoV-2 (COVID-19) Requisition

All information below is **required** by the U.S. Health and Human Services (HHS) Department and Centers for Disease Control (CDC).

ACCESSION LABEL

CLINICAL PATHOLOGY LABORATORIES
A Sonic Healthcare Company

PATIENT INFORMATION

Patient Name

Last Name ____ First Name ____ M.I. ____

Gender ☐ Female ☐ Male

Patient Address

____ City/State ____ Zip Code ____

Date of Birth ____ Patient I.D. *(optional)* ____ Patient Phone # ___ – ___ – ___

ACCOUNT INFORMATION

Account #: 255969

Client Name: LAB TESTING NEAR ME

Client Address: 11494 LUNA RD
FARMERS BRANCH TX
75234

Ordering Provider
DR NEAL ZEIGLER

Ordering Provider Phone # ____

PATIENT RACE *(REQUIRED BY HHS AND CDC)*

☐ American Indian or Alaskan Native (AI) ☐ Native Hawaiian or Other Pacific Islander (PI)
☐ Asian (AS) ☐ White (W)
☐ Black or African American (B) ☐ Multiple/Other/Refused (O)

PATIENT ETHNICITY *(REQUIRED BY HHS AND CDC)*

☐ Hispanic/Latino (H) ☐ Non-Hispanic/Latino (N) ☐ Unspecified/Not Given/Refused (U)

COVID-19 CLINICAL HISTORY *(REQUIRED BY HHS AND CDC)*

First Test?	☐ YES	☐ NO	☐ UNKNOWN
Employed in Healthcare?	☐ YES	☐ NO	☐ UNKNOWN
Symptomatic as defined by CDC?	☐ YES	☐ NO	☐ UNKNOWN
If YES, then date of symptom onset (mm/dd/yy): ____			
Hospitalized for COVID-19?	☐ YES	☐ NO	☐ UNKNOWN
ICU for COVID-19?	☐ YES	☐ NO	☐ UNKNOWN
Resident in congregate care setting?	☐ YES	☐ NO	☐ UNKNOWN
Pregnant?	☐ YES	☐ NO	☐ UNKNOWN

COLLECTION DETAILS

Date Collected ____ Time Collected ____

BILLING AND INSURANCE

☑ Client Bill ☐ Insurance Bill *(attach copy of card)* ☐ Uninsured Patient *(complete section below for HRSA coverage)*

ICD-10 Diagnosis ____ ICD-10 Diagnosis ____ ICD-10 Diagnosis ____ ICD-10 Diagnosis ____

☐ Z03.818 Encounter for observation for suspected exposure to other biological agents ruled out
☐ Z20.828 Contact with and (suspected) exposure to other viral communicable diseases
☐ Z11.59 Encounter for screening for other viral diseases (asymptomatic)

INSURANCE INFORMATION *(IF APPLICABLE)*

Primary Insurance Name ____ Name of Policy Holder ____ Member ID ____ Group # ____

UNINSURED PATIENT INFORMATION

Driver License # ____ State of Issuance ____

TESTING OPTIONS

☑ 7305 SARS-CoV-2 by NAAT (PCR, TMA)

Source: ☐ Anterior Nares (AN) ☐ Bronchoalveolar Lavage (BAL) ☐ Nasal Turbinate (NT) ☑ Nasopharyngeal (NP)
☐ Oropharyngeal (OP) ☐ Tracheal Aspirate (TASP) ☐ Sputum (SP)

☐ 7304 SARS-CoV-2 Total Ab

☐ 7301 SARS-CoV-2 IgG Ab

PATIENT COPY

Step By Step Instructions To Get Your Results

I've Been Testing At Lab Testing Near Me, Now What?

Monitor the email you provided to our staff during your testing registration, as access to your patient portal will be sent straight to your inbox.

Please note you must set up your patient portal before your results can be shared.

Contact us if you have not received an email to set up your portal within 3 hours of testing.

***Check spam and junk folders for email if not visible in inbox.

Scan the code above for instructions on settling up your patient portal.

(Click View PDF)

Plano

1905 Preston Rd,
Plano, TX 75093
10:00am - 6:00pm
214-499-2274

Richardson

15767 N Coit Rd,
Dallas, TX 75248
10:00am - 6:00pm
214-458-0999

Addison

15240 Dallas Pkwy,
Dallas, TX 75248
10:00am - 6:00pm
214-458-2616

Hulen

5900 S Hulen St,
Fort Worth, TX 76132
10:00am - 6:00pm
817-313-3592

info@labtestingnearmetx.com

labtestingnearmetx.com