Office Use Only

Patient ID: ______________

Insurance Co. ____________

CC/Cash Receipt #: _______

Results: __________________

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

Race

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ White
☐ 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

Financial Responsibility: (check one) Cash ______ Credit Card ______ Insurance __________

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 certify that the insurance information provided is accurate and the policy is active. I understand that Lab Testing Near Me will contact if additional information to file my claim. If my claim is denied, I understand that I will be billed for the services rendered.

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, 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.

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
IN THE LAST 48 HOURS:		
Have you had a fever (99.5 or higher)?	YES	NO
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
Have you been exposed to someone who has tested positive for COVID 19?	YES	NO
Have you taken part in activities that put you at a higher risk for COVID 19? (travel, large social gathering, or being in a crowded or poorly ventilated indoor setting?	YES	NO

If none of the above, what brings you in for testing?

____

Have you been fully vaccinated for the Covid 19 virus? If yes, Date:__________	YES	NO
Have you ever been diagnosed or tested positive for COVID? If yes, Date: _________	YES	NO

PATIENT NAME:____

PATIENT SIGNATURE:____

DATE:____

<u>Please read/check the following carefully:</u>

- 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 text, 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.