COVID-19 PCR TESTING CONSENT FORM

PATIENT INFORMATION

Last Name: ______________________ First Name: ____________________ Phone Number: ____________________

Email Address: ____________________ Gender: ❑ Male ❑ Female ❑ Other

Home Address: __________________________ City: ____________________ State: ______ Zip Code: ____________

Date of Birth: __________________________ Have you been vaccinated? ❑ Yes ❑ No

Have you ever been diagnosed with either of the following conditions? (Select all that apply)
❑ HIV ❑ Hepatitis C ❑ I have not been diagnosed with HIV or Hepatitis C

INSURANCE INFORMATION: Fill the appropriate category.

❑ If providing insurance information, I give consent that Save More Drugs, Dr. Laura Purdy, and affiliates may bill my medical insurance for the service provided.

☐ **Medicaid:**

Medicaid Provider: ______________________________ Policy/Member ID #: ______________________

Medicaid #: ____________________ Group #:____________________

☐ **Medicare Part B:**

Subscriber ID #: ____________________ Responsible Party: ______________________________

Policy Holder's Date of Birth: ____________________

☐ **Private Insurance:** Insurer: ______________________________ Member ID: ______________________

Bin #: ____________________ PCN: ______________________ Group #: ____________________

☐ **No Insurance**

I give consent to Save More Drugs Clinical Services to perform a nasal swab for a COVID-19 PCR Test. I understand that there is a slight risk of receiving a false negative or a false positive result. I have received a copy of the notice of Privacy Practices. I understand the notice of Privacy Practices provides an explanation of the ways in which my health information may be used or disclosed by the Pharmacy and of my rights with respect to my health information. I hal give consent to Save More Drugs Clinical Services to perform a COVID-19 Antibody Test. I understand that the antibody tests look for antibodies in your blood that can fight the virus that causes COVID-19. Antibodies are proteins created by your immune system that help you fight off infections. I understand this test does not confirm that I am protected from contracting COVID-19. The testing device we use is authorized for use by the FDA in the United States, however, like many other tests, is not FDA approved. I understand that there is a slight risk of receiving a false negative or a false positive result.

I have received a copy of the notice of Privacy Practices. I understand the notice of Privacy Practices provides an explanation of the ways in which my health information may be used or disclosed by the Pharmacy and of my rights with respect to my health information. I have been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.ve been provided with the opportunity to discuss concerns I may have regarding the privacy of my health information.

If guarantor/guardian, indicate your relationship to the recipient: ______________________________

Signature: ____

Print: ______________________________ Date of Signature: ______________________