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: _____ Primary Care Physician: _____

Racial/Ethnic Background (Please select all that apply):

❑ Asian ❑ Black ❑ White ❑ Hispanic ❑ American Indian/Native Alaskan ❑ Pacific Islander ❑ Other

Are you currently experiencing any of the following symptoms? (Please select all that apply)

❑ Fever ❑ Cough ❑ Sore Throat ❑ Runny Nose ❑ Shortness of Breath ❑ Wheezing ❑ Chest Pain

❑ Loss of Taste or Smell ❑ Chills ❑ Headache ❑ Muscle Aches ❑ Nausea or Vomiting ❑ Abdominal Pain

❑ Diarrhea ❑ Fatigue ❑ None of the above *If yes, date of symptom onset:* _____

Do you have any of the following underlying medical health conditions and/or risk behaviors? (Please select all that apply)

❑ Diabetes ❑ Severe Obesity (BMI 40+) ❑ Heart disease ❑ Chronic Renal Disease ❑ Chronic Liver Disease

❑ Chronic Lung Disease ❑ Immunosuppressive Condition ❑ Autoimmune Condition ❑ Current Smoker

❑ Substance Abuse or Misuse ❑ Disability ❑ Psychological/Psychiatric Condition ❑ None of the above

Have you recently had direct contact with someone who is confirmed to have COVID-19? ❑ Yes ❑ No

If yes, please explain: _____

In the last 14 days, have you traveled outside of Kentucky? ❑ Yes ❑ No *If yes, list locations traveled:* _____

Are you getting tested for international travel? ❑ Yes ❑ No Are you a healthcare worker? ❑ Yes ❑ No

Are you getting tested for a procedure or doctor's visit? ❑ Yes ❑ No Have you been vaccinated? ❑ Yes ❑ No

Are you a student? ❑ Yes ❑ No *If yes, what school do you attend?* _____

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 have 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: _____