

**MEMORIAL HEALTH COVID TESTING**

**PATIENT REGISTRATION**

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Time \_\_\_\_\_\_\_\_\_\_\_\_: \_\_\_\_\_\_\_\_\_\_\_\_ am/pm

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Sex: ( ) Female ( ) Male Race/Ethnicity\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HomeAddress\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt\_\_\_\_\_\_\_\_\_\_\_

City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_ Zip code\_\_\_\_\_\_\_\_\_\_\_County\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Reason for visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you come in contact or exposed to anyone who tested Positive with COVID 19? ( ) YES ( ) NO

Date of exposure: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Start date of symptoms: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT QUESTIONNARIE**

**Circle your symptoms**: Fever, Chills, Sore throat, Fatigue, Body aches, Cough, Headache, Congestion,

Loss of smell and taste, Nausea/ Vomiting/ Diarrhea, Abdominal Pain, Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Do you have any of the following risk factors?** Age >65, Pregnancy, Asthma, Diabetes, Live in nursing

home or long term facility, Are you a health care worker, first responder, law enforcement officer?

List any chronic medical condition that weakens your immune system \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INFORMED CONSENT FOR COVID-19 DIAGNOSTIC TESTING**

1. Authorization and Consent for Covid-19 Diagnostic Testing: I voluntarily consent and authorize Memorial Health Covid Testing (MHCT) to conduct collection, testing, and analysis for the purposes of a COVID-19 diagnostic test. I CONSENT TO RECEIVE MY RESULTS ELECTRONICALLY VIA EMAIL. I acknowledge and understand that my COVID-19 diagnostic test will require the collection of an appropriate sample by my healthcare provider through a nasopharyngeal swab, oral swab, or other recommended collection procedures. I understand that there are risks and benefits associated with undergoing a diagnostic test for COVID-19 and there may be a potential for false positive or false negative test results. I assume complete and full responsibility to take appropriate action with regards to my test results. Should I have question or concerns regarding my results, or a worsening of my condition, I shall promptly seek advice and treatment from an appropriate medical provider.

2. Patient Rights and Privacy Practices a) Notice of Privacy Practices and Patient Rights: (MHCT’s) Notice of Privacy Practices describes how it may use and disclose your protected health information to carry out treatment, initiate and obtain payment, conduct health care operations and for other purposes that are permitted or required by law. b) Disclosure to Government Authorities: I acknowledge and agree that MHCT may disclose my test results and associated information to appropriate county, state, or other governmental and regulatory entities as may be permitted by law.

3. Release To the fullest extent permitted by law, I hereby release, discharge and hold harmless, MHCT’s, including, without limitation, any its respective officers, directors, employees, representatives and agents from any and all claims, liability, and damages, of whatever kind or nature, arising out of or in connection with any act or omission relating to my COVID-19 diagnostic test or the disclosure of my COVID-19 test results.

**Sign \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

By selecting the ACKNOWLEDGEMENT during the registration process for COVID-19 Diagnostic Testing at MHCT, I acknowledge and agree that I have read, understand, and agreed to the statements contained within this form. I have been informed about the purpose of the COVID-19 diagnostic test, procedures to be performed, potential risks and benefits, and associated costs. I have been provided an opportunity to ask questions before proceeding with a COVID-19 diagnostic test and I understand that if I do not wish to continue with the collection, testing, or analysis of a COVID-19 diagnostic test, I may decline to receive continued services. I have read the contents of this form in its entirety and voluntarily consent to undergo diagnostic testing for COVID-19.



**MEMORIAL HEALTH COVID TESTING**

**Financial Agreement**

Thank you for choosing our services for your needs. Please read and sign the agreement below. It lays out billing, scheduling and cancellation procedures. If you have any questions please ask for clarification.

* Payment of all fees is expected at the time of service or via credit card on file. We will assist you in submitting claims to your insurance carrier.
* It is the client’s responsibility to check insurance benefits and coverage. You will be responsible for any non-covered services, deductibles, co-payments or co-insurances, as determined by your insurance carrier. Accounts unpaid by the insurance carrier greater than 90 days will be billed to the client.
* I hereby authorize payment of medical benefits directly to Memorial Health Urgent Care for all services rendered where applicable.
* Out-of-pocket payments can be made via credit/debit card, cash or check and are due on the day of visit. Please make checks payable to Memorial Health Urgent Care. There is a $35 fee for all returned checks.
* I hereby authorize Memorial Health Urgent Care to release to government agencies, insurance carriers and all others who are financially liable for my care, all information to substantiate payments for my care and to permit representatives thereof to examine and make copies of all records related to such care and treatment. I understand that if at any point my insurance coverage changes, I am to notify administrative staff prior to my next visit. Failure to do so will result in being personally and completely responsible for the full amount of all services.
* I will be responsible to pay a $50 late cancel fee for any missed or cancelled initial visits, not made at least 24 hours in advance prior to the scheduled appointment time.
* If I default on my account, I understand I will be subject to finance and/or legal fees in addition to the total account balance.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agree to the above financial and cancellation policies. In the case of default payment, I am responsible for full payment of the balance, interest accrued, and any collection costs and legal fees incurred to collect on this account. I understand the scope and limitations of my insurance coverage and agree to pay all fees not covered by my insurance plan. I have read, understand, and accept the information and conditions specified in this agreement.

**Client Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**