COVID-19 TEST CONSENT

First	MI	Last

Address	Apt/Unit #	City:	State	Zip code

DOB	SSN	Gender ☐ Male ☐ Female	Preferred Language

Phone (H)	(C)	PREFERRED METHOD OF CONTACT: ☐ Phone (Voice) ☐ Text ☐ Email

Get connected to the patient portal, pay bills online, access visit notes and receive information from Urgent Specialists. Your email address may be used by Urgent Specialists or one of our trusted partners to facilitate this. By providing your email address below you agree to these terms.

Email Address:	If not Self, Insurance Primary Person Name and DOB

RACE		ETHNICITY	MARITAL STATUS
White American Indian Asian Native Hawaiian Hispanic	Black or African American Other Alaskan Native Other Pacific Islander Declined	⎦ Hispanic/Latino ⎦ Not Hispanic/Latino ⎦ Declined	⎦ Single ⎦ Married ⎦ Widowed ⎦ Divorced ⎦ Declined

Emergency Contact	Phone	Relationship to Patient

☑ **COVID-19 Molecular Test: (Antigen and PCR)**

By signing below, I (or my authorized representative on my behalf) understand I am purchasing a COVID-19 Test Kit to use as directed by Urgent Specialists L.L.C. Urgent Specialists are utilizing a third-party laboratory to conduct this specific COVID-19 test. I understand this test **will be submitted** to my insurance company and if any part of the claim is denied, I will remain **solely responsible for the balance.**

☐ **Antibodies Test:**

By signing below, I (or my authorized representative on my behalf) understand I am receiving the COVID-19 Antibodies Test administered by Urgent Specialists I understand this test **will be submitted** to my insurance by Urgent Specialists. If the claim is denied by insurance, then I will remain **solely responsible** for the cost.

HIPAA NOTICE OF PRIVACY PRACTICES

Signature below is only acknowledgement that you have received the Notice of our Privacy Practices.

NOTICE OF PATIENT RIGHTS

Signature below is only acknowledgement that you have received the Notice of Patient Rights.

I understand, I will be notified of the results of this test by Urgent Specialists staff and if I wish for any additional person to receive the results, I may name them below. If left blank, no individual other than the patient will be authorized to receive information.

Individual/Company/Surgery Center: _____ **Date of Surgery:** _____

I understand,
- This authorization will remain in effect from the date signed below until the patient revokes it.
- I may revoke this authorization in writing, delivered by patient to Urgent Specialists.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected by the HIPAA.

Patient Signature (or Legal Guardian) _____

Name (Printed)_____ **Date:** _____

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