COVID -19 Consent Form

Today's Date_______/_______/_______ Patient Gender _____Male _____Female

Exposure date: ____________ Symptoms: ____

Patient Information

Patient: ____

Last Name First Name Middle Initial

SS# (Age 18 and up):______________________________ Date of Birth: ____________________________

Permanent Mailing Address: ____

Number & Street City State Zip

Patient Phone:______________________________ Patient Email: _________________________________

Marital Status: (Please circle one) Single Married Widow Divorced

Emergency Contact Name: ______________________ **Emergency Contact Phone: ___________________**

Physician Name: ____________________________ Office Phone: ________________________________

Authorize release of records to physician if needed (please circle): YES NO _______Initials

Reason for the test: (Please circle one) Symptomatic Travel School Work Other

Please Checkbox All Test Being Completed:

☐ 15 minutes Rapid Nasal Swab Test, $75 cost per test.

☐ PCR 48 Hour Nasal Swab Test, $175 cost per test.

NOTE: Sample is sent to University of Michigan Lab.

Insurance Information (NOT on the CARD) – MUST BE FILLED OUT!

Primary Insurance: __________________________ Subscribers Name: ___________________________

Subscribers Date of Birth: ____________________ Relationship to Patient: _______________________

Subscribers SS# (*if patient is a minor):* ____

Dear Patient,

The staff of Advance Urgent Care & Walk-In Clinic provides professional health services. Due to many changes in insurance policy, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. It is your responsibility to know your individual coverage. A charge of $35.00 will be applied to any account that is sent to collections. A $35.00 fee will be incurred for any returned checks. **Please remember your insurance policy is between you and your company and not with the Physician**. By signing below, you hereby authorize your insurance benefits to be paid directly to Advance Urgent Care & the on-staff physicians, realizing that you are responsible to pay non-covered services, and you hereby authorize the release of pertinent medical information to the insurance carriers.

RECEIPT OF HIPAA (Health Insurance Portability and Accountability Act) PRIVACY NOTICE

Advance Urgent Care is committed to maintaining the integrity of your protected health information and complies with all applicable state and federal regulations. In support of our policy of complying with all applicable regulations, Advance Urgent Care provides patients with the HIPAA Notice of Privacy Rights. I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Advance Urgent Care may use and disclose my protected health information with my permission. I understand that Advance Urgent Care reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me. While not required in order to receive treatment at Advance Urgent Care, we are obliged under federal regulations to ask that you sign an acknowledgement of the HIPAA Privacy Notice being made available to you. (Refusal to sign does NOT prevent the patient from being treated)

Signature of Patient or Parent/Guardian: _________________________________ Date: ____________________

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