



# COVID-19 TESTING - PATIENT CHECK IN WORKSHEET

First Name: \_\_\_\_\_ Middle: \_\_\_\_\_ Last: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_ Sex: Male / Female

Home #: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Cell #: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ Apt/Suite: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_-\_\_\_\_ Relationship: \_\_\_\_\_

Reason for your visit: COVID-19 Nasopharyngeal Serological Antibody Test

List All Medical Insurance(s): \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Address/Cross Streets: \_\_\_\_\_

Requested Testing Site: Westbank New Orleans River Parishes On-Site

**\*Please submit worksheet with a copy of ID/Drivers License AND copy of Insurance card (front and back)**

## ADDITIONAL INFORMATION

Race: American Indian/Alaska Native Asian Black/African American Native Hawaiian/Pacific Islander White Patient Declines

Ethnicity: Hispanic or Latino Not Hispanic or Latino Patient Declines

Preferred Language: English Spanish Vietnamese Other \_\_\_\_\_ Patient Declines

## AUTHORIZATION & AGREEMENT

### HIPAA Patient Consent

By signing below, I have read and fully understand the Patient Consent for Use and Disclosure of Protected Health Information, rev. 7/ 2016. I consent and agree to all of its terms and conditions. I understand copies of The Urgent Care's full Notice of Privacy Practices are available on request.

### Patient Responsibility and Financial Policy Clause

By signing below, I have read and fully understand The Urgent Care's Patient Responsibility and Financial Policy. I accept and agree to all of its terms and conditions. Specifically, I understand that I am responsible for any medical treatment and medical equipment not covered by my insurance plan or applied towards my copay, coinsurance, and/or deductible. These services include, but are not limited to: Injections (administration fee & medicine), IV treatments and fluids (initial IV treatment, hydration, medicine, etc.), and durable medical goods (crutches, walking boots, splints, slings, ace wraps, etc.) I understand that balances may be assessed interest and collection fees. I understand that any overpayments may remain as a credit balance on my account, to be applied to future charges, unless I request a refund. Credit balances remaining will be handled per the Patient Responsibility and Financial Policy may be assessed inactivity fees and/or processing fees if sent to the Louisiana Secretary of State LSA R.S. 9:151 et seq.

### Consent for Treatment

By signing below, I understand that I have a choice to be seen at The Urgent Care versus the hospital Emergency Department, my primary care, or a specialist. I authorize The Urgent Care to provide medical treatment and services to me. I understand I am authorizing The Urgent Care to treat me while I seek care from The Urgent Care or until I withdraw my authorization in writing. I also give consent to report all immunizations to LINKS, Louisiana's Immunization Registry.

Patient/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

I declare the above information is true. I authorize my insurance benefits to be paid to The Urgent Care. I understand that I am financially responsible for any charges that may not be covered by my insurance plan. I authorize my medical information to be released to my insurance company/ any of its affiliates for medical purposes.