DiagnosTEX Consultants, LLC & Concierge Urgent Care

COVID-19 Testing Bill Insurance

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Name: ____________________________________ DOB:_________________ Sex:____________________

Address:___________________________________ City:__________________ ST: ________ Zip:_________

Phone:_____________________ E-Mail:____

Reason for Test: **Test Date:________** **Testing Location:____**

☐ Recent Exposure ☐ Essential Worker

☐ Exhibiting Symptoms: (Circle all that Apply)

Chills Fatigue Muscle or body aches Headache New loss of taste or smell Sore throat

Congestion or runny nose Nausea or vomiting Diarrhea Shortness of Breath Cough Fever________

Other:____

☐ Previous positive test taken on:__________________

COVID-19 Testing Consent:

I give consent for DiagnosTEX Consultants, LLC & Concierge Urgent Care to perform a COVID-19 test on me. The testing process has been explained to me and I have had an opportunity to ask any questions I may have prior to the test. I understand that DiagnosTEX Consultants, LLC & Concierge Urgent Care cannot guarantee the accuracy of the results and that it may be necessary for me to undergo further testing***. I recognize that even if this test is negative, I can still contract COVID-19 in the future and should continue to practice safe social distancing.*** I understand that even though DiagnosTEX Consultants, LLC & Concierge Urgent Care is administering the test this does NOT create a patient/physician relationship. I authorize DiagnosTEX Consultants, LLC & Concierge Urgent Care to test me for COVID-19 and convey the results to me within 24 -48 hours after the test has been taken. I understand by undergoing the test DiagnosTEX Consultants, LLC & Concierge Urgent Care may have to report my results to all applicable federal, state and/or local governments. I have been made aware that my results will be available on DiagnosTEX Consultants, LLC & Concierge Urgent Care patient portal if I need to supply copies to Employers or Medical personnel in the future. I give DiagnosTEX Consultants, LLC & Concierge Urgent Care permission to bill and collect any and all payment from my Insurance Company(s) listed below. I understand I could have an out of pocket expense that DiagnosTEX Consultants, LLC & Concierge Urgent Care will bill.
Initial:__________________

Insurance Primary:

Insurance Name:____ ID#:_______________________

Group#:___________ Subscriber Name:_________________________ Subscriber DOB:__________________

Insurance Secondary:

Insurance Name:____ ID#:_______________________

Group#:___________ Subscriber Name:_________________________ Subscriber DOB:__________________

I voluntarily agree to DiagnosTEX Consultants, LLC & Concierge Urgent Care testing me for COVID-19.

Printed Name: ____ Date: _________________

Signature:____