COVID PATIENT REGISTRATION

NAME: _____

Phone Number: _____

1. Have you been a patient with Faster Care before? ___ Yes OR __ No

2. **Patient Medical Info:**

Are you experiencing symptoms? __ Yes OR __ No

When did you symptoms start? _____

Past Medical History:

_____

Height: _____ Weight: _____

3. **Vaccination Information:**

Did you receive the COVID-19 Vaccine? __ Yes OR __ NO

Type: __Johnson & Johnson __ Pfizer __Moderna

Vaccine Date: _____ & _____

Booster Date: _____ & _____

4. **Patient Info:**

   Last Name: _____ First Name: _____

   Date of Birth (MM/DD/YYYY): _____

   Sex: _____ SSN: ___-___-____

   Address: _____

   State, City, Zip: _____

   Phone # for COVID RESULTS: _____ OR _____

5. **Additional individual authorized to receive information related to today's COVID-19 Results (SKIP IF NO ONE):**
   Full Name: _____ DOB:_____
   Relationship: _____
   Type of Auth: ___Phone/Verbal ___Pick up Results

6. **Insurance Holder (SKIP IF SELF):**
   Relationship to patient: _____
   Last Name: _____ First Name: _____

   Date of Birth (MM/DD/YYYY): _____

   SSN: ___-___-____

   Address: _____

   State, City, Zip: _____

Signature of Patient or parent/guardian if patient is a minor.

_____ Date: _____

Faster Care Consent Forms:

7. **PRINTING YOUR COVID RESULT ONLINE:**

You will be able to view/print your COVID Results as well as other medical records online by registering for our patient portal.

E-mail Address (Print): _____

You will be emailed directions to set up your account.

By signing and dating this form, I am authorizing Faster Care to create a patient portal Logon ID and password for the patient listed above.

Signature: _____ **Date:** _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I also authorize Faster Care or my insurance company to release any information required to process my claims. I consent to treatment by the physicians of Faster Care and to appropriate tests for the presence of infection, such as, but not limited to Hepatitis B Virus, Hepatitis C Virus, or HIV if deemed necessary and authorize the withdrawal of blood or other body fluids for this purpose.

RECEIPT OF NOTICE OF PRIVACY PRACTICES: I verify that I have received a copy of Faster Care's notice of privacy practices.

I am aware that ALL radiographic studies including but not limited to x-rays, cat scans and ultra sounds will be read by a radiologist who will require a separate payment. All laboratory procedures not executed at Faster Care will also require a separate payment. The patient will be responsible for these charges, not Faster Care.

Payment for the patient portion will be collected at the time of service; including co-pays, coinsurance, and any portions of your unpaid deductible. Collection accounts will receive a $50.00 charge on all unpaid balances. Bounced checks will receive a $30.00 charge.

Providing your signature acknowledges that you have read, understood, and are agreeable.

Signature of Patient or parent/guardian if patient is a minor.

_____ Date: _____