

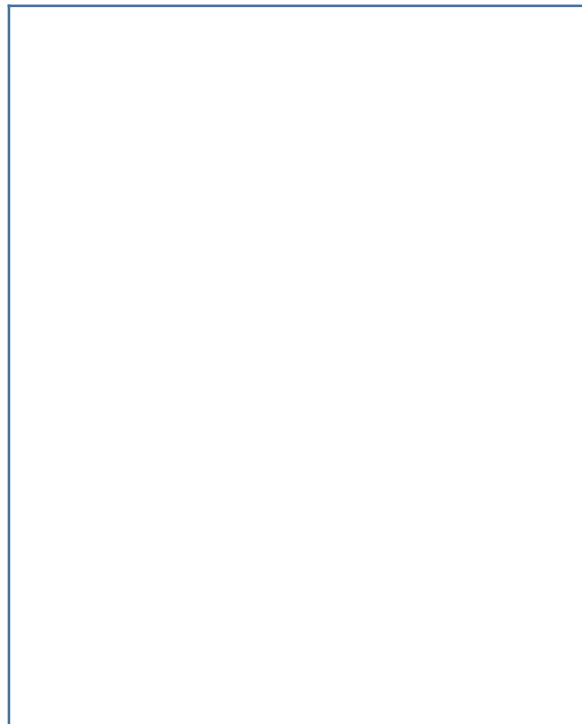


Mobile COVID-19 Test
Method: Nasopharynx Swab

(Please print legibly)

PATIENT NAME _____ DOB _____

Phone# _____ Home Address _____



By signing below, I authorize to receive a picture message of my COVID-19 results to the phone number provided above. ****Allow 24 hours for results**** If positive, I acknowledge that I will quarantine for 14 days and per CDC guidelines that two negative tests must be done 24 hours apart to be considered cleared of COVID-19. I understand that no test is 100% accurate and it takes 48-72 hours after exposure for a test to show positive. Example: If a patient comes in contact with a COVID-19 positive person, no test would show positive results in less than 48 hours.

A \$50 fee will apply for any canceled appointments. There is no refund once the test has been performed.

Patient Signature _____ Date: _____

Call (904)422-9856 when you arrive.