Tristan Medical Enterprises OHS

COVID-19 Consent

The rapid COVID-19 blood test is testing for antibodies specific to the 2019 novel coronavirus. The rapid test is done with blood via a finger stick and results in 10-15 minutes. Because the virus takes several days after exposure to produce antibodies, a nasal swab will also be performed in the case that I am presenting with symptoms if my provider deems it necessary. A positive IgG would indicate past exposure and likely "immunity." A positive IgM indicates an acute, current infection.

At this time, there is no treatment for patients who are stable with the infection and I understand that, if infected, I should remain quarantined for 14 days until retested to confirm immunity and seek emergency care should my condition worsen.

By signing this form, I understand that the rapid COVID antibody test may have false positives and false negatives and that a negative test cannot rule out infection if I have not yet started to produce antibodies to the virus. **As such, it is recommended that I be re-tested in seven days to verify the initial test if I test negative.**

By checking this box and initialing, **I agree** to allow Tristan Medical Enterprises to release my COVID antibody test results to my employer. ________ *(initial here)*

By checking this box and initialing **I do not agree** to allow Tristan Medical Enterprises to release my COVID antibody test results to my employer. __________ *(initial here)*

____

Patient name(s) and Signature(s) **Date**

If patient is under the age of 18,

____

Parent's/Legal Guardian's name and Signature **Date**

TristanMedical
NORTH ATTLEBORO CARE CENTER

Full Name: ______________________________ **DOB:** ______________

Allergies to Medications: ____

Medication list: ____

Medical Conditions: ____

Smoker (Circle One): Yes No Former

If Yes – how many packs per day: ________ **How many years:** ___________

Known COVID Exposures (Circle One): Yes No Unknown

If Yes – what was the date of exposure: ______________________________

International travel in the past 6 months (Circle One): Yes No

If yes – what date and to what location: ______________________________

Current symptoms (Check all that apply):

	Fever		Sore throat
	Chills		Diarrhea
	Cough		Nausea/Vomiting
	Shortness of breath		Rash
	Difficulty breathing		Loss of taste
	Fatigue		Loss of smell
	Body Aches		Dizziness
	Headache		Nasal congestion

Illness in past 6 months (Circle One): Yes No
If yes – when: ________________________

	Fever		Sore throat
	Chills		Diarrhea
	Cough		Nausea/Vomiting
	Shortness of breath		Rash
	Difficulty breathing		Loss of taste
	Fatigue		Loss of smell
	Body Aches		Dizziness
	Headache		Nasal congestion

TO BE COMPLETED BY MEDICAL STAFF ONLY:

Ht: _______ Wt: _______ T: ________ P: ________ O2sat: __________

Physical Exam:
Constitutional: NAD, Well-appearing, active and alert, A & O x 3, ______________________
HEENT: Normocephalic, Conjunctiva non-injected, Sclera non-icteric, Trachea midline, ____________
Lungs: No stridor, No tachypnea, ______________________________________
MSK: Normal movement of all extremities, No tremor, ____________________________
Skin: No jaundice, Good turgor, ______________________________________
____

Assessment:

	Z20.828 Exposure to 2019 novel Coronavirus
	Z03.818 Viral disease screening
	R05 Cough
	R50.9 Fever
	J02.9 Acute pharyngitis

Orders:

		Result
	Rapid COVID	
	COVID NP Swab	
	Rapid Influenza	
	Rapid Strep	

Plan:

Notice of Privacy Release Form

I, (print full name) ____

Date of Birth: __________ / __________ / __________

Received a copy of the Notice of Privacy from Tristan Medical on:

Today's date: __________ / __________ / __________

With my consent, the staff of Tristan Medical may call my home or any other designated location and leave a message on voicemail or in person in reference to any items that may assist the practice in carrying out typical office functions such as appointment reminders, Insurance issues, and any calls relating to clinical care including laboratory, x-ray results, and any other medical information requiring your contact.

With my consent, the staff of Tristan Medical may mail my home or any other designated location any item that may assist the practice in carrying out typical office functions such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

Signature ____

NOTICE OF PRIVACY PRACTICES

As required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually Protected Health Information (PHI). In conducting our business, we will create records regarding you and the treatment services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices concerning your PHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at this time.

We realize these laws are complicated, but we must provide you with the following important information:
- **How we may use and diagnose your PHI**
- **Your privacy rights in your PHI**
- **Our obligations concerning the use and disclosure of your PHI**

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

B. If you have any questions about this notice, please contact us.

C. We May Use And Disclose Your Individual Patient Health Information (PHI) In The Following Ways. The following categories describe the different ways in which we may use and disclose your PHI.

Treatment. Our practice may use your PHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests) and we may use the results to help us reach a diagnosis. We might use you PHI in order to write a prescription when we order a prescription for you. Many of the people who work for our practice - including, but not limited to,our doctors and nurses - may use or disclose you PHI in order to treat you or assist others who may assist in your treatment. Additionally, we may disclose your PHI to others who may assist in your care, such as your spouse, children, or parents.

Payment. Our practice may use and disclose your PHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover, or pay for, your treatment. We also may use and disclose your PHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your PHI to bill you directly for services and items.

Health Care Options. Our practices may use and disclose your PHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice.

Appointment Reminders. Our practice may use and disclose your PHI to contact you and remind you of an appointment.

Treatment Options. Our practice may use and disclose your PHI to inform you of potential treatment options or alternatives.

Health-Related Benefits and Services. Our practice may use and disclose your PHI to inform you of health-related benefits or services that may be of interest to you.

Release of Information to Family/Friends. Our practice may use and disclose your PHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.

Disclosures Required By Law. Our practice may use or disclose your PHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES. The following categories describe unique scenarios in which we may use or disclose your identifiable health information.

Public Health Risks. Our practice may use and disclose you PHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths
- Reporting child abuse or neglect
- Preventing or controlling disease, injury or disability
- Potential exposure to communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled
- Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required by law to disclose this information.