COVID-19 TESTING NEW PATIENT REGISTRATION FORM

Today's date _____ **Sex** M F **Date of Birth** _____

First Name _____ **Last Name** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone _____ **Cell Phone** _____

Email _____

Emergency Contact _____ **Relationship** _____

Contacts Cell Phone _____

I attest and agree that the above information is true and correct to the best of my knowledge. I further understand that any charges incurred by me in this office are my sole responsibility, despite any insurance plan, legal involvement, or settlement. In addition, I understand and agree that if my account is placed into collections, I am responsible for any and all collection fees. A copy of this document shall be treated as original.

PATIENT'S PRINTED NAME _____ **DATE** _____

PARENT or LEGAL GUARDIAN'S PRINTED NAME _____

PATIENT'S SIGNATURE _____
(if a minor, Parents or Legal Guardian Signature)

Downtown Gilbert Healthcare

Consent Form

OFFICE HOURS AND APPOINTMENTS

We consider an appointment to be an agreement between you and our facility. This is a busy practice and the employees who work here take pride in helping each and every person. If for any reason you need to but do not cancel your appointment, our company becomes unable to provide service to others during your scheduled time.

We are responsible to be onsite and provide our services, or to inform you otherwise; you are responsible for keeping the appointment or giving us a 48-business hours notice of cancellation for established patient appointments. For appointments we ask for a 48-business hour notice of cancellation.

PAYMENT AND CANCELLATIONS

Downtown Gilbert Healthcare requires payment in full at the time services are rendered. The cost for rapid COVID testing is $100, subject to change. For your convenience we accept all major credit cards, including Visa, MasterCard, Discover, and American Express payments. We accept payment via Zelle. We accept cash as payment. We also may be able to accept an HSA or Flex Spending account debit card as payment, but offer no guarantee of coverage related to using these insurance-related payment sources. We do not accept checks. No refunds are provided.

INSURANCE

The physicians of Downtown Gilbert Healthcare are not recognized providers for any insurance companies nor do we submit claims to insurance companies on your behalf. We will however, provide you with the information necessary for you to submit your claim to your insurance company. This does not guarantee any coverage from your insurance company.

Since I have chosen to obtain services, I agree to be financially responsible for any and all related charges, if they are not covered by my insurance.

MEDICAL EMERGENCIES

As we are a mobile lab with no set office hours, if you have a true medical emergency or serious medical concern please call 911 immediately.

SCOPE OF CARE

I understand and acknowledge that the providers of Downtown Gilbert Healthcare are not replacing my existing physician or primary care providers. I understand and acknowledge that they are providing a unique services, such as mobile laboratory testing, including rapid viral testing, or nutrient IV therapy. I will continue to seek care from my regular physicians. The sensitivity of the rapid COVID test we provide is 96%. We recommend following up this rapid test with a PCR test. If you are traveling, it is your responsibility to check with your airline for any further requirements.

By signing and submitting this form I acknowledge that I have been provided ample opportunity to read this document or that it has been read to me. I understand the above-stated office policies and the financial agreement with Downtown Gilbert Healthcare, and will comply with them in all respects.

_____ _____

Print Patient Name Signature

_____ _____

Print Patient Guardian Name Guardian Signature

_____

Today's Date