
## Patient Information

I am a person wanting to get tested for CoVid-19. ____

Gender: Male or Female

First Name:_____ Middle Name:_____ Last Name:_____

Street Address :_____

Street Address Line 2:_____

City:_____

Postal / Zip Code:_____

State / Province:_____

Date of Birth: Month:_____ Day:_____Year:_____

Ethnicity(Check one that applies)

Hispanic or Latin___
White__
Black or African American__
American Indian or Alaska Native___
Asian ___
Native Hawaiian or Other Pacific Islander__
Other ___

Email:_____ (* results will be emailed*)

Cell Phone:_____

Do you have a Driver's License, ID or Passport Number:_____

Upload Drivers License or ID Card.

Do you have medical insurance?  Yes or No

Primary Insurance Company's name: _____

Member ID :_____

Group ID :_____

Upload Insurance Card or Please bring your insurance card or a picture of it.

A Federal health care program (as under section 1128B(f) of the Social Security Act (42 U.S.C. 1320a-7b(f)), including an individual who is eligible for medical assistance only because of subsection(a)(10)(A)(ii)(XXIII) of Section 1902 of the Social Security Act

A group health plan or health insurance coverage or by a health insurance issuer in the group or individual market (as such terms are deemed in section 2791 of the Public Health Service Act (42 U.S.C.300gg-91)), or a health plan under chapter 89 of title 5, United States Code.]

## Health Screening

**Do you have any of the following symptoms? (Check all that apply)****

Fever or chills ___
Cough ___
Shortness of breath or difficulty breathing ___
Fatigue ___
Muscle of body aches ___
Headaches ___
New loss of taste or smell ___
Sore throat ___
Congestion or runny nose ___
Nausea or vomiting ___
Diarrhea ___
I don't have any symptoms ___

**Do you have any of the following conditions?(Check all  that apply)-***
Obesity ___
COPD ___
Congestive heart failure ___
Coronary heart disease ___
Diabetes ___
History of autoimmune disease ___
Immune 2deficiency (e.g. HIV)___
High blood pressure ___
I do not have any of the above conditions ___

**Have you been in personal contact with anyone that has tested positive for CoVid-19? ***

Yes __or No__

**Have you tested positive for CoVid-19 previously**

Yes __or No__

**Signature of Patient/Responsible Party: By signing below I consent to the use of information I have provided to facilitate treatment of CoVid-19 and any of my medical conditions necessary per Test USA or any medical facility I may be referred to by them.***

**Signature :_____ Date:_____**

The cost for your CoVid-19 test laboratory fee will be covered by your insurance. If insurance is inactive or you don't have insurance, your test will be processed through Cares Act or any federal funding program by the laboratory for reimbursement. In the event that you omitted insurance information or provided incorrect demographic information that delayed billing, you will be responsible for any balance not paid by your insurance company.


# HIPPA Release Consent for Emailing Results

I understand that the medical record released pursuant to this authorization could contain information concerning drug related conditions, alcoholism, psychological conditions, psychiatric conditions, and/or blood borne infectious disease, which are subject to federal and/or state restrictions on disclosure. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re- disclosed and no longer protected by these regulations. I hereby a3rm that I have read and fully understand the above statements and consent to the disclosure of the medical record for the purpose and extent stated above. HIPAA stands for the Health Insurance Portability and Accountability Act Information stored on our computers is encrypted Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it. Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA. The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website- http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email PATIENT CONSENT TO UNENCRYPTED EMAIL COMMUNICATIONS By signing below, you acknowledge your recognition and understanding of the inherent risks of communicating your health information via unencrypted email and hereby consent to receive such communications despite those risks.

Messages containing clinically relevant information may be incorporated into the medical record at the provider's discretion. By signing below, you also acknowledge that you have the choice to receive communications via other more secure means such as by fax. By signing below, you agree to hold USA Resource Group and Test USA harmless for unauthorized use, disclosure, or access of your protected health information sent to the email address you provide.