Noblesville Urgent Care COVID-19 Viral (Antigen or PCR) TESTING CONSENT FORM

Patient Name:_____Date of Birth:_____

COVID-19 Screening: *Have you experienced any of these symptoms in the last 14 days?*

Fever (>100.4ºF) or chills	□ YES	□ NO
Cough	□ YES	□ NO
Shortness of breath or difficulty breathing	□ YES	□ NO
Fatigue	□ YES	□ NO
Muscle or body aches	□ YES	□ NO
Headache	□ YES	□ NO
New loss of taste or smell	□ YES	□ NO
Sore throat	□ YES	□ NO
Congestion or runny nose	□ YES	□ NO
Nausea or vomiting	□ YES	□ NO
Diarrhea	□ YES	□ NO
Have you been in close contact with a person known/suspected to have Coronavirus (COVID-19)	□ YES	□ NO
Have you been diagnosed with COVID-19	□ YES	□ NO

Purpose of COVID-19 Viral (Antigen or PCR) Testing: *What is your reason(s) for testing?*

I have signs or symptoms consistent with COVID-19 If so, the date you start feeling sick: _____ OR how many days ago you start feeling sick? _____	□ YES	□ NO
I have been in close contact with a person known/suspected to have Coronavirus (COVID-19) If so, the date of exposure: _____ OR how many days ago you got exposed? _____	□ YES	□ NO
Public health surveillance	□ YES	□ NO
I have been diagnosed with COVID-19 and need test for resolution. If so, how many days have you been self-quarantine? _____ Please write test date(s): _____ and Please check test method(s): Antibody test(s): _____ or Viral test(s) (Nucleic Acid: _____ or Antigen: _____)	□ YES	□ NO
I plan to participate in special settings with vulnerable populations in close quarters for extended periods of time such as …	□ YES	□ NO
Surgery or Procedure	□ YES	□ NO
Travel	□ YES	□ NO
Nursing Home Facility	□ YES	□ NO
School or Sports	□ YES	□ NO
Work	□ YES	□ NO
Other reasons (Please list): _____ _____ _____	□ YES	□ NO

Noblesville Urgent Care Informed Consent for COVID-19 Viral (Antigen or PCR) Testing:

I give permission for Noblesville Urgent Care staff to perform COVID-19 viral (Antigen or PCR) testing. I certify that I have read through entirety of COVID-19 webpage on ***NoblesvilleUrgentCare.com*** for detailed COVID-19 test information, including the fact sheet for the Sofia 2 SARS Antigen FIA test & LabCorp's website for COVID-19 PCR Molecular Test. The testing process has been explained to me and I have had an opportunity to ask any questions.

I understand that COVID-19 viral testing can only be performed as part of an urgent care visit so I will see one of the providers who will help me to determine which COVID-19 viral testing is needed. *I will follow the return-to-work policy from your employer or school. I will call ISDH (Indiana State Department of Health) at 877-826-0011 (8 am to 5 pm daily) for further guidance.*

I understand that Noblesville Urgent Care cannot guarantee payment by my insurance company. I will receive a bill for anything not paid by my health insurance. If I have no insurance, I will pay the fee for the test in addition to the clinic visit fee. The fee for the Sofia 2 SARS Antigen FIA test [CPT 87426] is currently $100.00. I understand that I will receive a separate bill from LabCorp for the analysis of PCR Molecular Test.

I acknowledge that Noblesville Urgent Care cannot guarantee the accuracy of the result and that it may be necessary for me to undergo additional testing in the future. I recognize that even if I have a negative result now, I can still contract COVID-19 in the future. Administering the test does not create a patient/physician relationship between me and Noblesville Urgent Care or any of its employees, nor does it obligate Noblesville Urgent Care or its staff to perform any other care or treatment for me. I authorize Noblesville Urgent Care to receive my test results and convey them to me. I understand by undergoing the test Noblesville Urgent Care is required to report the results to the Indiana State Department of Health (ISDH) or other agencies.

I will continue to wear a mask in public to prevent new exposure to COVID-19.

I will continue to self-quarantine pending PCR Molecular test result from LabCorp.

If test result is POSITIVE, I will self-quarantine for at least 2 weeks and get in touch with ISDH (Indiana State Department of Health) for further instructions including contact tracing.

If I get sick including Trouble Breathing, Persistent pain or pressure in the chest, New confusion or inability to arouse, Bluish lips or face, I will go to nearby ER for further evaluation and treatment.

Name of Patient Printed: _____

Signature: _____

If minor, please sign by Legal Guardian and also print name of Legal Guardian

Date: _____

Witness: _____