Westlake Village Urgent Care, Occupational and Family Medical Clinic, Inc

COVID 19 TESTING AND/OR COVID 19 ANTIBODY TESTING DATE_____

LAST NAME_____ FIRST_____M_____

DATE OF BIRTH_____ GENDER: MALE___ FEMALE___

ADDRESS_____

CITY_____STATE_____ ZIP_____

Insurance_____(MC/ PPO) or _____ HMO/Cash Pay?

WHY DO YOU WANT TO BE TESTED? (CHECK ALL THAT APPLY)

____ I am currently having symptoms: (Short of Breath/ Difficulty Breathing, Cough, Fever, Fatigue, Body Aches, Chills, Sore Throat, Headache, Loss of taste or smell, Abdominal pain. Diarrhea)

____I was exposed _____ days ago to someone who tested positive.

____I am having a procedure and doctor _____requested it. Dr's FAX# _____-_____-_____

____**Travel or employment requirement._____

____***Other_____

____*** I have tested positive OR think I had it or was exposed OVER 4 WEEKS AGO (Date:___/____/____) and want to see if I have antibodies against it. (I will need a Blood Draw from a vein).

*(*** May not be covered by insurance if considered "elective" or **non-essential travel. If you have tested positive, you need to be cleared clinically based on time since your last symptoms. We do not retest via PCR)*

Clinic Staff can TEXT me my results and contact me at : (_____) _____ - _____

Email: _____@_____

Patient Signature: _____

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FOR STAFF USE

T_____ P_____ O2 Sat_____ RR_____ B/P _____/ _____

PMH: DM/HTN/IUP/CVD/ (LD-RAD/ TOB/V)/ GI/ IM-comp/_____

Westlake Village Urgent Care, Occupational and Family Medical Clinic
OFFICE POLICIES AND GENERAL CONSENT

Consent for Treatment

I hereby consent to and authorize administration of all diagnostic testing and treatment that may be considered advisable or necessary in the judgment of the attending physician of the Westlake Village Urgent Care. I confirm that my stated medical history is accurate to my knowledge. I recognize that medicine is not an exact science and that my diagnosis and treatment may involve risks. Furthermore, I acknowledge that no guarantees have been made to me as the result of examinations or treatments.

Personal Valuables

I understand and agree that the facility shall not be liable for the loss of or damage to any of my personal property.

Financial Agreement

I, the undersigned agree, whether I sign as the parent/agent/guardian or as the patient, that in consideration of the services to be rendered to the patient, I hereby obligate myself to pay the account of the facility in accordance with the regular rates and terms of the facility. Should the account be referred to collection, I the undersigned, shall pay actual collection expense. There will be an additional charge of $25.00 added to any "bounced"/returned check.

The Westlake Village Urgent Care will bill and or assist you in billing any third party payer. However, please understand that the balance in full is your responsibility. If your insurance carrier has not paid in thirty days, the balance will be turned to you/the patient and payment in full will be expected. It is the patient's responsibility to understand the extents and limitations of their own insurance policies.

All copays are due at the time of service. If we are an out of network provider or you do not have a third party payer, payment in full is expected at the time of service.

Assignment of Benefits: I, the undersigned, authorize, whether I sign as an agent or as the patient, direct payment to the facility of any insurance benefits otherwise payable to me for this office visit. I request payment of authorized benefits directly to Westlake Village Urgent Care for services furnished to me at this facility. I consent to the release of medical and other information related to such services for healthcare operations and to Medicare, my insurance company, HMO, other third party payers, or their third party administrators, in order to process and pay claims, determine benefits and perform quality of care reviews.

**Medicare does not cover tetanus shots or any preventative care.

HIPPA Notice of Privacy Practices

I have been provided with the 2 page document titled *"HIPPA Notice of Privacy Practices"* and agree to those terms. I understand that I may request a hard copy of this document at any time or download it from our website at www.westlakevillageurgentcare. com

Contact Mechanism

Urgent Care Staff may mail, email, TEXT or leave a detailed voice message for me regarding Test Results, Follow-up, Billing etc at the numbers and addresses on my file.

(____) - _____ - _____ _____@_____

_____ _____/_____/_____

Patient Name- Please Print Date of Birth

_____ _____/_____/___2020____

Signature of patient or authorized representative Today's Date