PLEASE PRINT CLEAR

OFF-SITE REGISTRATION FORM

Patient Name (Print): ______________________________ Date of Birth: ____________

Address: __________________________ Apt/Unit: _____ City/State: __________Zip:________

Cell Phone: _____________________________ Email: _______________________________

Gender: ___________ Race: _____________________ Hispanic/Latino: ____________________

Currently Insured: YES / NO

If you are currently insured your insurance carriers will be billed for services provided. Please PRINT applicable insurance information below, attach copy of Insurance Card if possible.

Insurance Carrier: ____

Member ID #: _________________________ Group # _____________________________
(As applicable)

Patient / Guardian Consents

I hereby authorize the NNHSC personnel to perform COVID-19 test.

I hereby authorize the release of information necessary to file a claim with my insurance company and assign benefits to the group indicated on the claim.

Name (Print): ____

____

Signature Date

NearNorth HEALTH SERVICE CORPORATION **PATIENT INFORMATION**

Please complete the following information:

Patient name_______________________________________ Date of birth: ________________

INFORMED CONSENT FOR CORONAVIRUS (COVID-19) TESTING

Please carefully read the following informed consent:

I authorize this COVID-19 testing unit to conduct collection and testing for COVID-19 through Nasopharyngeal (nose to throat), Oropharyngeal (mouth to throat), Oro-nasopharyngeal, Pharyngeal (throat swab), Nasal (nose swab) as ordered by an authorized medical provider or public health official.
I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.

I acknowledge that a positive test result is an indication that I must to self-isolate in an effort to avoid infecting others.

I understand that I am not creating a patient relationship with Near North Health Service Corporation by participating in testing. I understand the testing unit is not acting as my medical provider. Testing does not replace treatment by my medical provider. I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if my condition worsens.

I understand that, as with any medical test, there is the potential for false positive or false negative test results can occur.

I understand I need to be available to receive results by phone or email.

I understand that, as a result of the test, I may need to quarantine or isolate for several days.

I understand that if I am feeling sick or need medical attention I should contact a medical provider.

I understand that if I am having severe symptoms, I should go to the nearest emergency room.

I, the undersigned, have been informed about the test purpose. I voluntarily agree to test for COVID-19.

____ ________________

Signature of patient/guardian. Date

____

Relationship to patient

Revised 10/3/2020cf