COVID testing form – Medicare, Medicaid, Uninsured, Self-pay

First:	Last:	M:	DOB:	Phone:
Address:	City:	State:	Zip:	
Gender:	Allergies:	Emergency Contact Name & phone:		
Primary Doctor:	Dr. Address:	Dr. Phone #:		

Race: ( ) White ( ) Asian ( ) Black or African American ( ) American Indian or Alaska Native ( )Native Hawaiian or Pacific Islander ( ) Other ( ) Unknown

Ethnicity: ( )Hispanic/Latino ( )Not Hispanic/Latino ( ) Prefer not to answer | Email to Communicate:

( ) Medicare ( ) Medicaid ( ) Uninsured ( ) Self-pay | ID# | Effective date:

If uninsured only: | SSN# | DL# & State:

( ) I do not have medical insurance, Medicare, Medicaid or any commercial or government-funded health benefit plan. I am answer this question truthfully in order to have the cost of my test covered by US Department of Health & Human services(HHS) uninsured program. If I have active insurance & fail to provide that information, I may be charged the full price of the test.

Check all that apply below (all tests): ( )Cough (R05) ( )Shortness of Breath (R06.02) ( )Headache (R51)
( )Fever, unspecified (R50.9) ( )Sore throat (acute), (J02.9) ( ) New loss of taste) (R43.3) ( )Chills, no fever (R68.83)
( ) Diarrhea, Nausea /Vomiting ( )Suspected Exposure, not inhaled **(Z03.822)** ( ) Congestion or runny nose
( ) New Loss of smell (R43.0) ( )Exposure to Covid-19 patient (Z20.828) ( ) Fatigue, muscle or body aches
( )Suspected Exposure, congregate (Z03.818) ( ) No symptoms/exposure (Z11.59) Date of Symptom Onset:

Required SARS CoV-2 Survey Check all that apply (all tests) : ( ) This is my first COVID test ( ) I am a smoker
( ) I have been in an enclosed space with greater than 8 people with no social distancing ( ) I am in ICU
( ) I have been in contact with someone with COVID-19 in past 14 days? ( ) I traveled outside of state in last 14 days
( ) I have been advised to get COVID-19 test prior to medical procedure ( ) I am currently hospitalized
( ) I have tested + for COVID antigen in past ( ) I have tested + for COVID antibody in past
( ) I reside in a congregate care facility ( ) I am employed in healthcare setting ( ) I am pregnant

Antibody test only		
	Have been diagnosed as positive for COVID-19 with a swab test in past 10 days?	( )Yes ( ) No
	Have you had close contact with someone who has COVID-19 in the past 14 days?	( )Yes ( ) No
	Have you been feeling feverish or had a fever higher than 100.5F in past 3 days?	( )Yes ( ) No

I hereby grant permission to Baltimore Highlands Pharmacy to perform certain screening tests as set forth below at my direction, which may include obtaining specimens of mucus by nasal, nasopharangeal or oropharangeal swab or blood by venipuncture or finger stick. I authorize HPC to obtain these screening results and provide them to me via phone, email or mail. I agree to pay for the tests in full at the time of service. I understand that the testing has not been ordered by a physician and is being done for my own use and not for medical diagnostic or treatment purposes. Because the tests are not ordered by a physician, insurance coverage may not be available, including Medicare or Medicaid. Upon your request, HPC or it's affiliates may submit the tests to any insurance company for reimbursement. However if insurance does not reimburse due to any reason, I understand that I will be responsible for the Usual & Customary charge for these tests. I further understand that the test results will not be forwarded to any medical professional for diagnosis of any medical condition. It is my responsibility to share the test results with my physician at my sole option. I, alone, am responsible for obtaining medical information, treatment or services from a doctor or other health care provider in relation to test results. I authorize HPC to report the administration of this test to the state per regulations. I understand the state may use my information and contact me for any purpose deemed necessary. I understand these tests have not been cleared or approved by the FDA and all these tests have been authorized by FDA under EUA's for use by authorized laboratories.
I have been provided with, read and understood the patient handouts or factsheets for these tests. I understand the risks, limitations, nature of these tests.
I hereby and for my heirs, executors, administrators, successors and assigns release, acquit and forever discharge HPC, its subsidiaries and affiliates, and each of their agents, employees, officers, directors, servants, successors, heirs, executors, and administrators, (collectively, "HPC"), of and from any and all claims, actions, causes of action, demands, rights, damages, injuries and property damage and the consequences thereof resulting or to result from the testing. I acknowledge that I have read this release form prior to signing it and that I understand its contents. I understand and agree that I will not be able to sue HPC for any injury or property damage I may suffer as a result of the testing. I HEREBY CERTIFY THAT I HAVE READ THE ABOVE ACKNOWLEDGEMENT AND HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS ABOUT ITS CONTENTS. BY SIGNING BELOW, I CONSENT TO UNDERGO THE SELF-DIRECTED LABORATORY TESTING UNDER THE CONDITIONS SET FORTH HEREIN.

Patient/Guardian Signature: Date:

PHARMACY USE ONLY

Test (s) administered	Exp date & lot # of test	Manufacturer	Date	Time	Route/site	Pharmacist Sign, Lic #

Adverse Reactions? Yes No (If yes, please explain on reverse side of form)

Test result -Rapid Antigen: ( ) Positive ( ) Negative **Antibody:**( ) Positive ( ) Negative **Date Reported to state:**

Pharmacy Location: Baltimore Highlands Pharmacy | 4109 Annapolis Road, Baltimore, Maryland 21227 | P: 410-636- 1035

PRIVATE AND CONFIDENTIAL: This communication and any attachments to it contain individual Protected Health Information (PHI). The disclosure of such information is governed by the Health Insurance Portability and Accountability Act (HIPAA). If you have received this communication from the sender in error please notify the sender immediately and destroy the communication received.