LEXINGTON PRESCRIPTION CENTER
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Specimen ID: (for lab use)

PATIENT INFORMATION ☐ Rapid Covid AG Test ☐ Rapid Covid PCR Test ☐ Covid Antibody Test

NAME: Last First M.I.			**Home Phone:**
Date of Birth:	**Sex:** M F	**Email address**	**Cell Phone:**
ADDRESS: Street City County State Zip Code			

Race: Please check one

__ American Indian/Alaskan Native
__ Asian
__ Black / African American
__ Hawaiian/Pacific Islander
__ White
__ Unknown
__ Other: _____

Ethnicity: Please check one

__ Hispanic or Latino
__ Not Hispanic or Latino
__ Unknown
__ Other: _____

Please circle the correct answer (Y=yes N=No U=Unknown)

1. Is this your first Covid test of any kind? Y N U
   If NO, have you ever tested POSITIVE for Covid? Y N U
   If so, when? _____
2. Are you employed in Healthcare? Y N U
3. Were you a resident in a congregate care setting (nursing home, residential care for people with intellectual and developmental disabilities, psychiatric treatment facilities, group homes, board and care homes, homeless shelter, foster care or other setting? Y N U
4. Are you pregnant? Y N U
5. Have you had all, or part of a Covid vaccination? Y N U

When do you think you were exposed to Covid -19?
(testing should take place 5-7 days after exposure for best results) **Date of exposure:** _____

Are you currently experiencing symptoms? Y N
(symptoms may occur 2-14 days after exposure to the virus)

Have you had symptoms within the past 14 days? Y N
Date of symptom onset: _____

Symptoms - check all that apply: (testing should take place within the first 5 days after symptoms start for best results)

__ Fever or chills __ Cough __ Shortness of breath or difficulty breathing __ Fatigue
__ Muscle or body aches __ Headaches __ New loss of taste or smell __ Sore throat
__ Congestion or runny nose __ Nausea or vomiting __ Diarrhea

PHYSICIAN INFORMATION (Optional)

Practice Name:	**Practitioner:**	**Phone #:**

CONSENT AND RELEASE *To agree to participate in this test, please initial boxes, sign, print name and date this form. Thank you.*

☐ ***I have read, and I understand the "Fact Sheet for Patients" provided to me.***
☐ ***In consideration of my participation in this test, I hereby agree to assume all risks. I also understand that results are not designed to replace the care or advice of a medical provider. I understand that if I receive abnormal laboratory test results, I should promptly consult with a physician.***
☐ ***This test will not be billed to insurance by Lexington Prescription Center. You will receive a receipt and invoice after testing to submit to insurance if you chose. Coverage is not guaranteed. Your insurance may reimburse the full amount, a portion of the amount, or not at all.***

_____ _____ _____
Signature of Participant **Printed name of participant** **Date**
(or parent or legal guardian if patient is under 18 years of age) **(or parent or legal guardian if patient is under 18 years of age)**

For Lab use only:

SPECIMEN COLLECTION INFORMATION

Collection Date Time Initials	**SPECIMEN SOURCE:** ***Swab of Internal Nose***	**Remarks:**

SARS-CoV2 TEST RESULTS

☐ **BD Veritor System for Rapid Detection of SARS-CoV2 Antigen in Respiratory System**

Testing date: **Tested by:**

☐ **Presumptive negative test for SARS-CoV-2 (no antigen detected)**

☐ **Positive test for SARS-CoV-2 (antigen detected)**

☐ **Mesa Biotech Accula System for detection of SARS-CoV-2 N gene in nose by NAA with probe detection**

Testing date: **Tested by:**

☐ **Negative test for SARS-CoV-2 (not detected)**

☐ **Positive test for SARS-CoV-2 (detected)**

LEXINGTON Rx CENTER
800 South Main St., Lexington 463-9166

COVID TESTING AND PAYMENT INFORMATION

Please arrive on time. If you are going to fill out paperwork at the Pharmacy, please arrive a few minutes early.
Please park in front of the Pharmacy, next to the small, green shed for testing.
After filling out your information, please remain in your car and call the Pharmacy at 463-9166 to let us know you are ready. Someone will be with you shortly to begin your test.
Participants and passengers are required to wear masks.

Testing Prices

Rapid Covid Antigen Test:	$129.00	(Results are ready in ~20 minutes after collection)
Rapid Covid PCR Test:	$169.00	(Results are ready in ~30-40 minutes after collection)
Covid Vibrant Antibody Test	$169.00	(Results are back in ~3-4 days after collection)
Covid Vibrant PCR Test	$199.00	(Results are back in ~ 2-3 days after collection)

Payment for testing is due before testing will be performed. This test is NOT billed to insurance by Lexington Prescription Center. You will receive a receipt and an invoice after testing is complete to submit to insurance is you choose. Coverage is not guaranteed. Your insurance may reimburse the full amount, a portion of the amount, or not at all. Insurance may not reimburse if testing is for travel purposes. It is best if you call your insurance company prior to testing if you have questions regarding reimbursement.

Payment Information

We accept cash, checks, or credit cards. If you are paying by credit card, you may give your card to the person performing the testing **OR** you may fill out the credit card information below.

Patient Name: _____ Date of Birth: _____

Name on Credit Card: _____

CC #: _____

Exp. Date: _____ CVV (security code): _____ Billing Zip Code: _____

Visa Master Card American Express Discover Debit Card

By signing below, I authorize Lexington Prescription Center to charge the credit/debit card using the information I have provided.

Signature: _____ Date: _____

Vehicle Description

Make: _____

Model: _____

Color: _____