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- Inside PT
- Rapid Flu
- Rapid Strep

TODAY'S DATE: _____

REASON FOR TEST (PLEASE CHECK ONE **)**

Are you here for surveillance/screening or uninsured? (for example: return to work, return to school without exposure, travel, or any other event)? If yes, no insurance accepted. **SELF PAY ONLY.**

<input type="checkbox"/> RAPID ANTIGEN \$100 (results in 15 minutes)	<input type="checkbox"/> RT-PCR \$200 (results in one hour)
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Are you here for a suspected exposure to COVID-19 or are you experiencing symptoms? (Most insurance accepted.)

<input type="checkbox"/> RAPID ANTIGEN (results in 15 minutes)	<input type="checkbox"/> RT-PCR \$200 (results in one hour)	<input type="checkbox"/> QUEST PCR (results in 1-3 days)
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SYMPTOMS: (CHECK ALL THAT APPLY):

- NONE COUGH HEADACHE RUNNY NOSE VOMITING FEVER/CHILLS FATIGUE
- LOSS OF TASTE SORE THROAT OTHER: _____

Duration of Symptoms: N/A 1-3 DAYS 3-7 DAYS GREATER THAN 7 DAYS

MEDICAL HISTORY (CHECK ALL THAT APPLY): _____ NONE _____ HIGH BLOOD PRESSURE _____ DIABETES
 _____ HIGH CHOLESTEROL _____ THYROID DISEASE _____ OTHER: _____

PATIENT NAME: _____ **DATE OF BIRTH:** _____

GENDER: MALE/FEMALE **CELL PHONE #:** _____

EMAIL ADDRESS: _____

WRITE YOUR NAME AND DATE OF BIRTH ON ALL TEST SWABS AND/OR TUBES PROVIDED

By signing this form, I consent to a low to mid complexity visit and authorize the release of any medical or other information necessary to process this claim. I request payment of benefits to the party rendering who accepts assignment. I assume responsibility for any co-pay and/or deductible associated with my visit. I also understand if I feel ill and/or cannot manage my symptoms, I should seek medical attention as soon as possible.

PATIENT SIGNATURE: _____