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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.**

☐	RAPID ANTIGEN $100 (results in 15 minutes)	☐	RT-PCR $200 (results in one hour)

☐ Are you here for a suspected exposure to COVID-19 or are you experiencing symptoms? (Most insurance accepted.)

☐	RAPID ANTIGEN (results in 15 minutes)	☐	RT-PCR $200 (results in one hour)	☐	QUEST PCR (results in 1-3 days)

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

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: _____