COVID-19 COLLECTION REGISTRATION

Name (First, Middle, Last)

Address

City State Zip

Sex ☐ M ☐ F

Date of Birth Age

Responsible Party or Parents Name (if minor)

Guarantor's SSN Date of Birth

Marital Status ☐ S ☐ M ☐ D ☐ W

Race
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White

Ethnicity
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

Drivers License Number

Home Phone

Cell Number Email

(Please check YES to receive texts/emails from Rapid Care Group)

Social Security Number

Primary Insurance Information

Insurance Company Name

Member ID Number

Claims Address

City State Zip

Telephone

Rapid Care Walk-In Medical Group, Inc.
4062 Flying C Road, #41
Cameron Park, CA 95682
Phone 530/676-8234
Fax 530/676-0819

COVID-19 Testing : Informed Consent

PATIENT NAME ______________________ **DATE** __________

Please carefully read and sign the following Informed Consent:

a. I authorize Rapid Care Walk-In Medical Group to conduct collection for COVID-19 through Nasopharyngeal swab.

b. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.

c. I acknowledge that a positive test result is an indication that I must self-isolate and/or wear a mask or face covering as directed in an effort to avoid infecting others.

d. I understand that Rapid Care Walk In Medical Group is not acting as my medical provider, this collection does not replace treatment by my medical provider, and 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.

e. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks. I have been given the opportunity to ask questions before I sign, and I have told that I can ask additional questions at any time. I voluntarily agree to this nasopharyngeal swab for COVID--19

SIGNATURE (Patient or legal Custodian/Authorized Representative) ______________________ **DATE** __________

Relationship to Patient if signed by another party ______________________ **DATE** __________

You may obtain a copy of our *COVID-19 Informed Consent*, including any revisions at any time by contacting: Rapid Care Walk-In Medical Group, Inc., 4062 Flying C Rd., #41 Cameron Park, CA 95682, Phone: 530/676-8234