COVID REGISTRATION

In-Office COVID-19 Antibody / PCR (Circle One)

(Please Complete ALL Sections)

SAVE PRINT RESET

Patient Information

Date:_____

Name:_____

DOB:_____ Age:_____ M / F

SSN:_____

Address:_____

_____

City, State, Zip:_____

PHONE

Home:_____ Cell:_____

Work:_____

Email:_____

HOW DID YOU HEAR ABOUT US ?

GOOGLE FACEBOOK TV WORD OF MOUTH

Health Insurance Information

Insurance Company:_____

Policy #:_____

Group #:_____

Insured Name:_____

DOB:_____

Relationship to Insured (Check one)

☐ Spouse ☐ Child ☐ Parent ☐ Other

GUARANTOR (REQUIRED if patient is a minor)

Name:_____

DOB:_____

SSN:_____

Method of Payment Credit,

Co-Pay, Coinsurance, **CASH**

(must be exact change) OR CREDIT CARD

Valenex will file these claims on patients' behalf and will make every attempt to have the insurance carriers cover the charges associated with the visit and test. Valenex will refund patients any funds paid by the insurance carriers that would have gone towards their out of pockets costs. Also, if your insurance carrier denied the claims all together, the charges associated with the visit and test are the patient's responsibility.

Assignment of Benefits:

I hereby assign Valenex and my providers payment from all third party payers with whom I have coverage or from whom benefits are or may become payable to me, for the charges of my healthcare services I receive for, related to, or connected with this visit and any future visit for which I have medical insurance coverage.

Patient or Responsible Party _____ (Please initial)

Consent and Authorization for Release of Information: Cooperation:

I hereby authorize Valenex and my providers to release copies of my billing and medical records, and applicable healthcare information, to ensure payment for healthcare services I receive for, related to, or connected to this visit(s), to secure additional treatment if needed and to otherwise facilitate healthcare operations related to the following persons or entities: any Valenex Labs provider, my referring or treating providers, the Guarantor to my accounts, and third party payers* or their agents. I also authorize the release of my healthcare information to regulatory entities and accrediting organizations as necessary to secure payment for service provider to me.

Patient or Responsible Party _____ (Please initial)

By signing below, I authorize to receive a picture message of my COVID-19 results to the phone number provided above. **Allow 24 hours for results** If positive, I acknowledge that I will quarantine for 14 days. If you are a healthcare provider or someone with significant face to face contact with others, per CDC guidelines that two negative tests must be done 24 hours apart to be considered cleared of COVID-19. I understand that no test is 100% accurate and it takes 72 hours after exposure for a test to show positive.

I agree that a $15 fee will apply for any canceled appointments. There is no refund once the test has been performed.

Signature of Patient or Legal Representative

Date _____/_____/_____

_____