Collector's Initials:

COVID Testing Patient Intake Form

Please PRINT

Today's Date: - -

Legal Name

First Name: Middle I: Last Name:

Date of Birth (Month/Date/Year): - -

Address:

☐ Randolph ☐ Perry City State Zip

County: ☐ St. Clair ☐ Washington **Contact Phone Number**: ( ) -

☐ Other:_____

To receive an invitation to view your results on the portal, please provide your email address.

Email Address: (Adults Only)

For Minor Children: Parent/Guardian Info ☐ Mother ☐ Father ☐ Guardian

Full Legal Name:

Full Mailing Address: ☐ Same

Contact Phone Number: ☐ Same

Sex: ☐ Male ☐ Female

Race:

☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Other:
☐ Unknown
☐ Refuse to Answer

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Not Latino
☐ Unknown ☐ Refuse to answer

Name of your Primary Care Physician:

Personal History:

Have you been tested for COVID in the Past?	☐ Yes	☐ No
Do you work in Healthcare?	☐ Yes	☐ No
Are you currently pregnant?	☐ Yes	☐ No
Have you been exposed to someone who is positive with COVID?	☐ Yes	☐ No
Are you having symptoms?	☐ Yes*	☐ No

*If you answered yes, you are having symptoms, please check all that apply:

☐ Fever ☐ Sore Throat ☐ Tiredness
☐ Shortness of Breath ☐ Cough ☐ Headache
☐ Loss of taste or smell ☐ Chest pain or pressure ☐ Aches and Pains

CONSENT: I have had an opportunity to review the Consent for Inpatient/Outpatient Treatment, Authorization for Release of Information and General Conditions for Admission printed on the back of this form. I accept the terms therein agreement. In the case of minor patient unaccompanied by the parent or guardian: I authorize Sparta Community Hospital to collect the specimen in my absence.

Patient/Parent/Guardian Signature: _____

CONSENT FOR INPATIENT/OUTPATIENT TREATMENT, AUTHORIZATION FOR RELEASE OF INFORMATION AND GENERAL CONDITIONS FOR ADMISSION

1. I believe I have a condition requiring health care services for the purpose of diagnosis and/or medical/surgical treatment. I consent to the provision of medical and/surgical care by my physician, consulting physicians, and other health care providers. Such care may include, but is not limited to, diagnostic and therapeutic tests and procedures and treatment as may be ordered by my physician, and/or his/her designees including consulting physicians. This consent includes but is not limited to the performance of invasive diagnostic procedures, administration of fluids, blood and/or blood products/components, medications, and any radiology procedures.

I UNDERSTAND:

2.1 The practice of medicine and surgery is not an exact science. I acknowledge that no guarantees have been made to me as to the diagnosis or result of examination or treatment in this hospital.

2.2 It is customary, except in emergency circumstances, that no substantial procedures will be performed upon a patient unless and until he/she has/had an opportunity to discuss them with the physician or other health care professional to the satisfaction of the patient. I have the right to consent or refuse consent to any proposed procedure or therapeutic course.

2.3 No patient will be involved in any research or experimental procedure without his/her full knowledge and consent.

2.4 Any authorization or consent that I have given may be cancelled or revoked by me in writing up until the time of treatment.

2.5 I have a right to express a concern or grievance regarding any quality of care issue either informally or formally through the patient grievance mechanism established by the hospital.

3. I am aware that among those who will be attending patients at this hospital there are medical, nursing and other health care personnel who are in training. Unless I direct otherwise in writing, such personnel may be present during patient care assisting in or providing care as part of their education. I also consent to still or motion pictures and closed circuit television monitoring for the purpose of patient safety, medical documentation or for furthering the education of such students and the staff of this hospital, unless directed otherwise in writing.

4. I understand that the hospital and the independent contractor physicians who provide care at the hospital use a joint Notice of Privacy Practices to comply with federal and state privacy rights and protections for patients. I further understand, acknowledge and agree that the use of a joint Privacy Notice rather than the use of separate notice and forms from the hospital and the doctors, is solely for my convenience as a patient and to improve my access to the separate health care services that the hospital and the doctors independently provide. I also understand, acknowledge and agree that by signing this consent the physicians who provide care at the hospital are independent contractors and are not agents, servants or employees of the hospital, unless otherwise identified; the physicians are solely responsible for their own compliance with state and federal privacy laws; and nothing in the privacy notice is meant to imply, infer or create any agency or employment relationship between the physicians and the hospital, either actual or implied, nor does the privacy notice alter, limit or modify any other consents for treatment or procedures I may sign during the time I am provided care at this facility.

5. I understand and agree that money, jewelry and other valuables should not be brought into the hospital. If I do bring them into the hospital, I agree to notify nursing staff. Such valuables should be deposited with the hospital or sent home by me with a responsible person. I agree that I will not hold Sparta Community Hospital liable for the loss or damage to any money, jewelry, glasses, dentures, documents, fur coats, or articles, goods, or property of any kind and description that I maintain in my possession.

6. I authorize Sparta Community Hospital to retain, preserve and use for scientific or teaching purposes or to dispose of any specimen or tissue taken from my body during my hospitalization.

7. In the event I am transferred to another health care facility, or require services such as home health care, for the continuity of care purposes, I authorize Sparta Community Hospital to release information and/or copies of my medical record or portions thereof to such other health care facility and/or physician in the event of such transfer. I further authorize any physician and the facility to which I am transferred to provide information to Sparta Community Hospital upon request of the hospital regarding care, condition and treatment.

8. In the event a health care provider sustains exposure to my blood or body fluids, I give permission for a sample of my blood to be drawn and tested for infectious diseases of any nature and description.

9. **RELEASE OF INFORMATION**

9.1 I authorize Sparta Community Hospital to release and/or send any medical information deemed by it to be necessary for the processing and payment of my hospital bills to an insurance company or other third party payer who is or may be responsible for paying any part of my medical treatment. I understand that this information may include the diagnosis of and treatment for mental illness, drug and alcohol abuse. This release includes the results of any blood tests that may be performed to determine the presence of the Human Immunodeficiency Virus (causative agent of AIDS). I understand that this authorization is furnished to enable the hospital on behalf of itself, the physicians for whom the hospital is authorized to bill, and also physicians who bill on behalf of themselves and myself, to obtain or attempt to obtain proceeds, benefits or amounts due to me or to members of my family from insurance companies or third party payers due to my treatment and hospitalization. In consideration of the hospital's cooperation in securing or attempting to secure said amount on my behalf, I release the hospital, its agents, servants, employees and attorneys from all responsibilities and/or liabilities incidental to their release of my hospital records and other information. I further authorize the hospital to release and/or send copies of my records or portions thereof to my referring physicians and to physicians on the staff of the hospital or other hospitals which were consulted in regard to my treatment, for their use in releasing information to third parties for the purpose of billing and collecting amounts due to them for services rendered. I further agree, whether I act as agent for the patient or as patient, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay the account of the hospital and/or treating, diagnosing or prescribing physician in accordance with the regular rates and terms of the hospital. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and costs. All delinquent accounts bear interest at 1½ % per month for 18% per annum on any unpaid balance. Self-pay account is delinquent if not paid 45 days after date of service.

9.2 I understand that the hospital may need to review the care and treatment rendered to me during the course of my hospitalization and any subsequent care. I consent and authorize any health care provider to provide to the hospital or its designee, including the quality improvement or risk management coordinator, information concerning my condition, care, treatment, and any event or occurrence while at Sparta Community Hospital or relating to a transfer or referral for follow-up care. This consent and authorization for release of information can be terminated by me in writing at any time. A photocopy of this release and authorization shall be sufficient authorization for any reason to respond to a request from the hospital or its designee for information concerning the subject of this authorization.

10. I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid Services or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for services to the physician or organization furnishing the services or authorize such physician or organization to submit a claim for Medicare for payment for me. I understand that I am responsible for any charges not covered by health insurance.

11. I do acknowledge and certify that I have read the general conditions of admission and that I am the patient or I am duly authorized to execute this acknowledgement on behalf of the patient. I accept the terms therein this agreement. If I should leave the hospital without the written consent of my attending physician, I hereby relieve said physician and the hospital of all responsibility for any action.