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Covid -19 Health and Wellness Assessment

Consent Patient

Information

Test Location *

First Name *

Last Name *

Date of birth *

Month day Year

Gender *

- [ ] MALE
- [ ] FEMALE
- [ ] prefers not to answer

Race *

- [ ] American Indian or Alaska Native.
- [ ] Asian.
- [ ] Black or African American.
- [ ] Native to Hawaii or another Pacific island.
- [ ] White.
- [ ] Prefer not to answer.

Ethnicity *

- [ ] Hispanic
- [ ] Non-Hispanic
- [ ] Unknown
- [ ] Not Provided

Email *

example@example.com

Phone *

Address *

Street Address Street Address

Line 2

City State / Province

Zip Code / Zip Code

Insurance Information

Please Note: If you do not provide the patients detailed insurance information, their file will be flagged and they will not be able to receive their test on campus.

Do you have Health Insurance? *

- [ ] Yes
- [ ] No

Insurance Company Name

Member ID or Subscriber ID

Group Number

If you do not have a group number enter the plan type(HMO, PPO, Medicare, etc.)

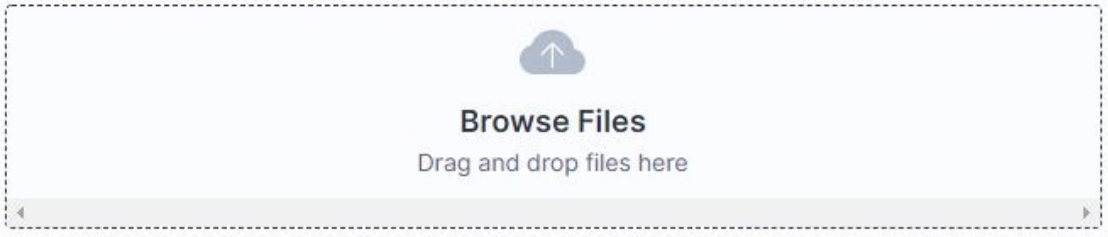
Name of the Insured Person

First Name Last Name

Relationship to the Insured person

- [ ] Self
- [ ] Guardian

Insurance Card Front and Back Photo



Please upload photos of the front and back of your insurance card

Authorization To Bill Insurance

I hereby authorize and direct the above insurance company to pay benefits due in accordance with the terms of my policy payable to Malibu Medical Corporation, 23661 Pacific Coast Highway Malibu, CA 90265

●I authorize Malibu Medical and HCCL Labs to release any information needed by the insurance company regarding this claim.

●I request payment of insurance benefits be paid directly to the Malibu Medical Group and HCCL Labs.

Signature:

Date

COVID ATTESTATION OF UNINSURED PATIENT

Please complete the following information if you are currently uninsured. Please note this information is required in for your COVID-19 testing to be paid for by the federal government

Patient Name

First Name Last Name

You must provide one of the following identifiers

Social Security Number OR Driver License information

Social Security Number

OR

State ID #

State

CERTIFICATION OF NO COVERAGE

I do not have health care coverage such as individual, employer-sponsored, Medicare or Medicaid coverage.

Therefore, I affirm and attest the above patient qualifies as uninsured according to the COVID-19 Uninsured Program in the Coronavirus Aid, Relief, and Economic Security (CARES) Act (P.L. 116-136).

Signature

FULL LEGAL NAME

First Name Last Name

Informed Consent

COVID-19 Testing : Informed Consent

a. I authorize this COVID-19 testing unit to conduct collection and testing for COVID-19 through a saliva collection, NasoPharyngeal swab, anterior nares swab, as ordered by an authorized medical provider or public health official.

b. I authorize my test results to be disclosed to the SMMUSD representatives as deemed necessary for the enforcement of public health policy and district protocol. Individuals including but not limited to; SMMUSD administrators, site Principal, Vice Principals, and SMMUSD associated health staff. Additionally, results will be disclosed to the county, state, or to any other governmental entity as may be required by law.

c. I understand that under no circumstances does Malibu Medical Corp share or transfer any information, other than results to administration and CalRedie, as required by state law.

d. 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.

e. I understand the testing unit is not acting as my medical provider, this testing 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.

f. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result. I acknowledge my acceptance that the district will not accept repeat tests from samples collected on a different day as evidence of a false positive and that a negative test means that SARS-CoV-2 was not detected but could still be present.

Financial Policy:

I understand that result return times are not guaranteed and that all laboratory results are generated by HCCL which Malibu Medical Corp has no control over. I hereby authorize and direct the above insurance company to pay benefits due in accordance with the terms of my policy payable to Malibu Medical Corporation, 23661 Pacific Coast Highway Malibu, CA 90265 and HCCL Laboratories ●I authorize Malibu Medical and HCCL Laboratories to release any information needed by the insurance company regarding this claim.

Signature

Relationship to Patient

- ☐ Self
- ☐ Guardian