REGISTRATION FORM – COVID TESTING

Form must be filled out completely in order to be registered.
The purpose of this registration is for COVID Testing only.

1. PATIENT INFORMATION

1.First Name:	2. Last Name:			3. Middle Initial:
4. Date of birth:	5. Age:	6. SSN:	7. Female	Male (Circle One)
8. Current Street Address: (No P.O. Boxes)				
9. City:		10. State:	11. ZIP Code:	
12. Home Phone:	13. Cell Phone:	14. Work Phone:	Ext:	
15. E-mail Address:				

2. RESPONSIBLE PARTY

16. Name:		17. Relationship:	
18. Address:			
19. City:		20. State:	21. ZIP Code:
22. Home Phone:	23. Cell Phone:	24. Work Phone:	Ext:
25. E-mail Address:			

3. EMERGENCY CONTACT

26. Name:		27. Relationship:	
28. Address:			
29. Current address:			
30. Home Phone:	31. Cell Phone:	32. Work Phone:	Ext:
33. E-mail Address:			

4. INSURANCE INFORMATION

34. **Primary** Insurance Co. Name:			
35. Subscriber Name:		36. Subscriber Date of Birth:	
37. Policy Number:		38. Group Number:	
39. **Secondary** Insurance Co. Name:			
40. Subscriber Name:		41. Subscriber Date of Birth:	
42. Policy Number:		43. Group Number:	
44. **Medicaid Managed Care Organization** Name:			
45. Medicaid-MCO Policy Number:		46. **Medicaid** Recipient Number:	

47. Primary Care Provider Name:			
48. Address		49. Phone Number	
50. Registered By:			Date:

INFORMED CONSENT FOR CORONAVIRUS (COVID-19) TESTING

Please carefully read the following informed consent:

1. I authorize Sadler Health Center to conduct collection and testing for COVID-19 through a nasopharyngeal swab (a swab inserted into my nose) and/or Serology antibody test (blood draw).

2. I understand that I am not creating a patient/provider relationship with Sadler Health Center or any member of the Sadler Health Center by receiving a COVID-19 test. I understand that Sadler Health Center is not acting as my medical provider and that testing does not replace treatment by my medical provider.

3. I take full responsibility to take appropriate action with regards to my test results when I receive them. I agree I will seek medical advice, care and treatment from my medical provider if I have questions or concerns after I receive the test, or if my condition worsens.

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

5. If applicable, by signing the HIPAA Authorization on the other side of this paper, I authorize my test results to be disclosed to my employer [listed in the back of this form].

6. I can request a copy of Sadler Health Center's Notice of Privacy Practices by contacting the Practice Manager at 717-960-4329.

7. I acknowledge that a positive test result is an indication that I must self-isolate in an effort to avoid infecting others.

8. I understand that there is the potential for false positive or false negative test results.

9. I, the undersigned, have been informed about the COVID-19 test purpose, procedures, possible benefits and risks, and I have received a copy of this Informed Consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask other questions at any time. I voluntarily agree to testing for COVID-19.

Printed Name of Individual	Date of Birth
Signature of Individual/Guardian	Today's Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO EMPLOYER

(Please complete if you would like your testing information released to your employer)

I authorize Sadler Health Center to release to _____ (Corporation/Name of Employer), the results of my COVID-19 test so that they can determine whether or not I have tested positive for COVID-19.

I further understand that this authorization can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance on it. I understand that I may refuse to sign this authorization.

This authorization will expire within one (1) year unless specified below.

Sadler Health Center, its employees and officers and attending physician are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.

Please note such information may be re-released without Sadler Health Center's knowledge or authorization.

_____ _____

Name of Individual Date

_____

Signature of Individual/Guardian