Please complete the following information:

COASTAL MED
Primary and Urgent Care

Office Number: (239) 931-6049
Fax Number: (239) 931-4986
Email: Info@cmurgentcare.com
8921 Dani Drive, Suite 100,
Fort Myers, FL, 33966

Patient Name: _____
DOB: _____ M: F: _____
Phone Number: _____
Patient Address: _____
Patient County Of Residence: _____
Insurance O
No Insurance O
Reason For Testing : _____

Please circle an answer choice for the following questions

Do you live in a group home, assisted living center, or other facility with more than 3 other people older than 60 years old?
Yes No

Do you work in a hospital, long-term care facility, or assisted living facility?
Yes No

Have you traveled anywhere outside of Florida in the past month, and if so where?
Yes _____ No

Have you been in close contact (within 6 feet) with someone confirmed to have COVID-19
Yes Unknown

Testing Eligibilty

COVID-19 diagnostic testing, authorized by the Food and Drug Administration under an Emergency Use Authorization (EUA), will be used today. This test is meant for use in individuals with signs and symptoms compatible with COVID-19.

Please mark the symptoms you are currently experiencing:

Fever ___ Muscle Aches ___ Headache ___ Cough___ Nausea and Vomiting___
Tiredness/Fatigue___ Sore Throat___
Other_____

Test Options

O **RAPID COVID Antigen**
O **PCR - MOLECULAR TEST**

Test Turn Around Time
RAPID COVID: Same Day Results
PCR: 2-4 Days For Results

Height: _____

Weight: _____

Temp: _____

O2: _____

HR: _____

Testing performed at Coastal Med Urgent Care (CLIA#45D2009077) Medical Director: Alan Obregon, M.D. This test has FDA authorization or EUA (Emergency Use Authorization). However, such approval/ clearance is not required, as the laboratory is regulated and qualified under CLIA to such testing. This test is used for clinical purposes, and should not be regarded as investigational or for research.

INFORMED CONSENT FOR CORONAVIRUS (COVID-19) TESTING

Please carefully read the following informed consent:

a. I authorize this COVID-19 testing unit to conduct collection and testing for COVID-19 and influenza through a nasopharyngeal swab, as ordered by an authorized medical provider or public health official.
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 continue to self-isolate in an effort to avoid infecting others.
d. I understand that I am not creating a patient relationship with Coastal Med Urgent Care by participating in testing. I understand the testing unit is not acting as my medical provider. Testing does not replace treatment by my medical provider. 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 false positive or false negative test results can occur.
f. I acknowledge that I have been given a copy of Coastal Meds Notice of Privacy Policy.
I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I may request 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.

AGREEMENT FOR SELF-ISOLATION

The local health jurisdiction has determined that if you are under suspicion for having COVID-19 due to symptoms and testing request, that it is necessary to be placed in isolation in order to prevent the transmission of this infection. It is important for you to comply with this Isolation Agreement in order to protect the public's health. Thank you for agreeing to cooperate.

Please carefully read and comply with the following statements:

a. I understand that I may be infected with the virus causing COVID-19 and that I meet criteria for isolation.
b. I agree that while I wait for my COVID-19 test results, I will remain in self-isolation.
c. I agree that if my COVID-19 test results are positive, I will remain isolated for 10 days from this day of testing OR until at least 72 hours after my symptoms have resolved, whichever is longer.
d. I agree that if my COVID-19 test results are negative, I will remain isolated until at least 72 hours after my symptoms have resolved.
e. I understand that if I am not isolated while ill, I could pose a substantial threat to the health of other persons.
f. I agree that I will not come into contact with any other person who is not isolated or ill due to potential COVID19 infection.
I, the undersigned, have been informed about the 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 and to self-isolation.

_____ _____

Signature of patient/guardian **Date**

HIPAA PRIVACY AND RELEASE OF INFORMATION AUTHORIZATION

Patient Name: _____
Patient Date of Birth: _____

I hereby authorize COASTAL CARE HEALTH SYSTEM INC. and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.
I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.
I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it's employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization.
I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.
I have been advised of this practice's Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.
If applicable, Legal Representatives sign below:
By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member's behalf with respect to this authorization form.

Uninsured attestation (ONLY FOR UNINSURED PATIENTS):

I attest as the patient or guarantor of this account, that I have no insurance for this service and I have no inpatient or outpatient insurance coverage at any hospital or healthcare facility that would cover these services.
If insurance is available and not provided, I understand that I will be responsible for the cost of the test at a rate of $125/test.
The cost of an office visit is NOT covered by the Cares Act.

Signature: _____ Date:_____

Patient Name:_____ Date: _____

Patient Signature: _____

*** Please save and email completed form along with insurance and ID card to:**
info@cmurgentcare.com to expedite processing.********