Portneuf Medical Center Laboratory

The laboratory tests that you are having performed today fall under a special category as follows:

Initial Here _____ ☐ Covid 19 Antibody Test ☐ Covid 19 PCR	1. Insurance companies, Medicaid and Medicare will not accept billing for self-directed testing. 2. A copy of the results are only available through the https://mychart.portneuf.org/ MyChart Portal. You must supply a valid email address to receive a sign up code. 3. Notice of privacy practices have been disclosed to me. 4. You are responsible to consult a physician for interpretation and care if results are abnormal. 5. You are responsible to contact a physician for further care if the test results are normal and symptoms continue. 6. It is your responsibility to follow-up with a medical provider for diagnosis or treatment. 7. A blood draw will be required for Covid-19 Antibody Testing for IgG Antibodies. This test lets you know if you were exposed. Cost of the test is $95.00 and will be billed to my insurance. 8. Nasal pharyngeal Swab for active Covid-19 Antibody via PCR testing. The cost of this test is $300 and will be billed to your insurance. 9. We will not collect co-pays for today's testing to limit exposure, but your insurance may require the copay on the balance bill.
Email Address	
Cell Phone	(_____) _____ - _____

Patient Full Name: _____Maiden:_____
Date of Birth: _____ Social Security Number: _____ Sex: _____
Marital Status: ____Race:_____ Ethnic Background: _____Religious Preference:_____
Primary Language: _____Primary Physician_____
Place of Birth: _____
Physical Address: _____ City: _____ ST:___Zip:_____
Mailing Address:_____ City: _____ ST:___ Zip:_____
Is the patient a Veteran? *Y/N*

Employer _____ Employment Status: *FT/ PT*
Employer Address: _____ City: _____ ST:____ Zip:_____
Employer Phone ( )_____

(This information is only needed if the patient is under 18 years of age.)
Guarantor Name: _____ Relationship to Patient: _____
Date of Birth:_____ Social Security Number: _____
Phone ( ) _____
Employer:_____ Employment Status: *FT/PT* Occupation: _____
Employers Address: _____ City: _____ ST:____ Zip:_____
Spouse Name: _____ Date of Birth: _____Social Security:_____
Phone Number: ( ) _____ Employer: _____
Emergency Contact: *Someone not living at the same address and at a different phone number.*
Name: _____ Relationship to Patient: _____ Phone ( ) _____

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ID 83201 (208) 239-1671

WELLNESS SCREENING
WITH DIRECT ACCESS
PATIENT TESTING

Insurance information:

☐ **Check to certify that I do not have insurance.**

Primary Insurance: _____ Policy #_____ Group #_____
Insurance Billing Address:_____ City:_____ ST:___ Zip _____
Policy holders name: _____ Date of Birth: _____
Relationship to patient:_____
Secondary Insurance: _____ Policy #_____ Group # _____
Insurance billing Address: _____ City: _____ ST:___ Zip_____
Policy Holders name: _____ Date of Birth _____
Relationship to Patient:_____

1) Is this your first COVID test? Y / N
2) Are you a Healthcare Employee? Y / N
3) Are you symptomatic as defined by the CDC? Y / N

- Fever or chills
- Cough
- Shortness of breath or difficulty breathing
- Fatigue
- Muscle or body aches
- Headache
- New loss of taste or smell
- Sore throat
- Congestion or runny nose
- Nausea or vomiting
- Diarrhea

If yes, what was the date you started displaying symptoms? _____

4) Are you a resident in a congregate care setting (Nursing home, group homes etc.)? Y / N

5) Are you currently pregnant? Y / N

6) Have you been hospitalized due to COVID-19? Y / N

7) If you have been hospitalized due to COVID-19 were you in the ICU? Y / N

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I consent to having these tests done. I have read the above statements and consent to have my blood drawn. I had an opportuni ty to ask questions, if needed, and understand t
their meaning.

CONSENT TO CONTACT

By providing us with your landline or cell phone number(s), you give your consent for us, or agents, and to our collection ag ents, to contact you at these numbers, or, at any number that is later a cquired for you, and, to leave live, or pre-recorded messages regarding any accounts or services.

Your agree, in order for us to service our account or to collect any amount you may owe, we may contact you by telephone at a ny telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text message or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and /or use of an automatic dialing device, as applicable. I/we have read this disclosure and agree that the l ender/creditor may contact me/us as described above.

RELEASE OF PATIENT INFORMATION

The Hospital may use or disclose all or any part of the patient's records in accordance with the Hospital's current Notice of Privacy Practices.

Signature (patient or guardian:_____

Date:_____

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