AccessMD URGENT CARE

1010 Woodman Dr.
Dayton, OH 45432
937-525-2288

COVID-19 SCREENING QUESTIONS

CHECK ALL THAT APPLY WITHIN THE LAST 14 DAYS:

- ☐ COUGH / CONGESTION / RUNNY NOSE
- ☐ SORE THROAT
- ☐ FEVER OR CHILLS
- ☐ LOSS OF TASTE / SMELL
- ☐ EXPOSURE (Dated: _____)
- ☐ TRAVEL / EVENT / REQUIRED (return-to-work)
- ☐ HEAD OR BODY ACHE / JOINT PAIN
- ☐ NAUSEA / VOMITING / DIARRHEA
- ☐ SHORTNESS OF BREATH
- ☐ _____

PATIENT INFORMATION

NAME: _____ DOB: _____ Gender (Circle): M / F

Required to be Sent Results *Cell Phone*: _____ *Email*: _____

Address: _____ City: _____ State: _____ Zip: _____

INSURANCE:

Primary Insurance: _____ ID#_____ Group# _____

Subscriber name: _____ DOB: _____

Secondary Insurance: _____ ID#_____ Group# _____

Subscriber name: _____ DOB: _____

RESULTS:

AUTHORIZATIONS:

By signing this consent form, I acknowledge that I have read, understand, and voluntarily consent to authorize the following:

_____ **(Initial)** I will receive AccessMD Urgent Care alerts via text, email, and patient portal

_____ **(Initial)** I understand a Negative Rapid COVID-19 test does not preclude infection, is presumptive, and should be confirmed with lab-based RT-PCR testing if I have had known exposure, are exhibiting symptoms, or otherwise clinically indicated

_____ **(Initial)** I understand that if I have a Positive COVID-19 test result, have had a known exposure, and/or are exhibiting symptoms, it is recommended by AccessMD that I follow-up with a provider visit for further evaluation and management

_____ **(Initial)** I authorize the administration and cost of all medical procedures, tests, x-ray, and medication for myself and my dependents

Guarantee of Payment:

_____ **(Initial)** IF NO INSURANCE: current self-pay pricing applies and is due at the time of service before leaving our facility

_____ (**Initial)** INSURANCE: Assignment of Benefits: I authorize payment directly to AccessMD Urgent Care for all benefits otherwise payable to me. I understand that I am financially responsible for all charges not covered by insurance. I authorize AccessMD Urgent Care to submit claims to my insurance carrier as well as medical records required to evaluate these claims for payment.

Receipt of Privacy Practices:

By signing this consent form I acknowledge that a copy of the Notice of Privacy Practices of AccessMD Urgent Care has been offered/is available to me upon request.

Patient / Responsible Party Signature:_____ Date:_____

Release of Medical Records:

I authorize AccessMD Urgent Care to release verbally, electronically, and/or in writing confidential medical information obtained during the course of my examination and/or treatment to any person or entity including my insurance carrier, employer (if treatment is related to employment), and/or other healthcare provider(s) for purpose of treatment, payment of charges, or quality assurances and utilization review. I understand that should I not choose to release my medical records to a specific entity and/or person(s), I must specifically state so in writing for inclusion in my medical record.

Patient / Responsible Party Signature:_____ Date:_____