



(Please Complete ALL Sections)

COVID REGISTRATION

In-Office COVID-19 Antibody / PCR (Circle One)

Patient Information

Date: _____
 Name: _____
 DOB: _____ Age: _____ M / F
 SSN: _____
 Address: _____

 City, State, Zip: _____
 PHONE
 Home: _____ Cell: _____
 Work: _____
 Email: _____

HOW DID YOU HEAR ABOUT US ?

GOOGLE FACEBOOK TV WORD OF MOUTH

Health Insurance Information

Insurance Company: _____
 Policy #: _____
 Group #: _____
 Insured Name: _____
 DOB: _____
 Relationship to Insured (Check one)
 Spouse Child Parent Other
 GUARANTOR (REQUIRED if patient is a minor)
 Name: _____
 DOB: _____
 SSN: _____

Method of Payment Credit,
 Co-Pay, Coinsurance, **CASH**
 (must be exact change) OR CREDIT CARD

Ace Labs Medical will file these claims on patients' behalf and will make every attempt to have the insurance carriers cover the charges associated with the visit and test. Ace Labs will refund patients any funds paid by the insurance carriers that would have gone towards their out of pockets costs. Also, if your insurance carrier denied the claims all together, the charges associated with the visit and test are the patient's responsibility.

Assignment of Benefits:

I hereby assign Ace Labs and my providers payment from all third party payers with whom I have coverage or from whom benefits are or may become payable to me, for the charges of my healthcare services I receive for, related to, or connected with this visit and any future visit for which I have medical insurance coverage.

Patient or Responsible Party _____ (Please initial)

Consent and Authorization for Release of Information: Cooperation:

I hereby authorize Ace Labs and my providers to release copies of my billing and medical records, and applicable healthcare information, to ensure payment for healthcare services I receive for, related to, or connected to this visit(s), to secure additional treatment if needed and to otherwise facilitate healthcare operations related to the following persons or entities: any Ace Labs provider, my referring or treating providers, the Guarantor to my accounts, and third party payers* or their agents. I also authorize the release of my healthcare information to regulatory entities and accrediting organizations as necessary to secure payment for service provider to me.

Patient or Responsible Party _____ (Please initial)

By signing below, I authorize to receive a picture message of my COVID-19 results to the phone number provided above. **Allow 24 hours for results** If positive, I acknowledge that I will quarantine for 14 days. If you are a healthcare provider or someone with significant face to face contact with others, per CDC guidelines that two negative tests must be done 24 hours apart to be considered cleared of COVID-19. I understand that no test is 100% accurate and it takes 72 hours after exposure for a test to show positive. I agree that a \$15 fee will apply for any canceled appointments. There is no refund once the test has been performed.

Signature of Patient or Legal Representative

Date ____/____/____