FOR OFFICIAL USE ONLY

ECLRS: _____

EMAILED: _____

Island Prescription Center

1728 GRAND ISLAND BLVD GRAND ISLAND, NY 14072

NPI: 1689894909 Phone: (716)773-5599 Fax: (716)773-5665

CLIA #33D2184418 CHESTER FOX, MD. MEDICAL DIRECTOR

COVID-19 ANTIGEN / RT-PCR TESTING PATIENT INTAKE FORM

LAST NAME_____ FIRST NAME_____ DATE OF BIRTH_____

STREET ADDRESS_____ CITY_____

STATE_____ ZIP_____ COUNTY_____ HOME/CELL PHONE _____

EMAIL: _____

PRIMARY PHYSICIAN AND PHONE # _____ GENDER M / F PREGNANT Y / N

RACE CIRCLE ALL THAT APPLY:

BLACK/AFRICAN AMERICAN WHITE ASIAN AMERICAN INDIAN OR ALASKAN NATIVE

NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER UNKNOWN OTHER

IS THIS YOUR FIRST COVID TEST Y / N (CIRCLE) HAVE YOU RECEIVED COVID VACCINE Y / N

ARE YOU A HEALTHCARE EMPLOYEE Y / N (CIRCLE) DATE THESE SYMPTOMS BEGAN?_____

CREDIT CARD NUMBER _____EXP DATE _____ CVV _____

PAYPAL:_____ CASH:____

COVID-19 Testing : Informed Consent

Please carefully read and sign the following Informed Consent:

1. I authorize ISLAND PRESCRIPTION CENTER (IPC)to conduct collection and testing for COVID-19 through a nasopharyngeal swab. Based on my results, additional testing may be needed for confirmation.
2. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.
3. I understand that I am not creating a patient relationship with IPC by participating in testing.
4. I understand that IPC is not acting as my medical provider, this testing does not replace treatment by my medical provider, and 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.
5. I understand that the antigen test will produce one of two results; a positive test result indicates that antigens for SARS-CoV-2 were detected, and I am infected with the virus and presumed to be contagious. I must self-isolate and/or wear a mask or face covering as directed, in an effort to avoid infecting others. A negative test result means that antigens for SARS-CoV-2 were not present in the specimen above the limit of detection. A negative test result means that antigens/viral RNA for SARS-CoV-2 were not present in the specimen above the limit of detection. However, for an antigen rapid COVID-19 test, a negative result does not rule out COVID-19 and should be treated as presumptive and confirmed via a molecular assay, if necessary for patient management.
6. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.

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 additional questions at any time. I voluntarily agree to this testing for COVID-19 and I acknowledge that I have read, understand, agree, certify and/or authorize the information above and further agree to hold harmless Ivylea Pharmacy, including its employees, agents, and contractors from any and all liability and claims.

_____ (Print Name) Date_____

Signature of Patient/Legal Representative _____

THIS SECTION FOR OFFICAL USE ONLY

Date of Test_____ Time test administered_____ Results Read at_____

LOT_____ Expiration_____

Island Prescription Center

1728 GRAND ISLAND BLVD GRAND ISLAND NY 14072
NPI: 1689894909 Phone: (716) 773-5599 Fax: (716) 773-5665

CLIA #33D2184418 CHESTER FOX, MD. MEDICAL DIRECTOR

HIPAA Email Consent

VERY IMPORTANT! PLEASE READ!

·HIPAA stands for the Health Insurance Portability and Accountability Act

·HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information

·Information stored on our computers is encrypted

·Most popular email services (ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email

·When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.

·Email is a very popular and convenient way to communicate for a lot of people, so the federal government has provided guidance on email and HIPAA. See https://www.hhs.gov/hipaa/for-professionals/faq/570/does-hipaa-permit-health-care-providers-to-use-email-to-discuss-health-issues-with-patients/index.html

·The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send that patient personal medical information via unencrypted email

*****I understand the risks of unencrypted email and do hereby give permission to ISLAND PRESCRIPTION CENTER to send my COVID test results via unencrypted email.**

_____ (Print Name) Date_____

Signature of Patient/Legal Representative _____