___ New Patient
___ Existing Patient

Existing Patient: Please revise all information that has changed since your last visit

COVID-19 TESTING

Date ___/___/____ Last Name_____First Name_____MI_____

Street Address: _____

City: _____ State _____ Zip_____

Cell Phone_____ Home Phone_____Work Phone_____

E-mail Address:_____

Gender: Male___ Female___ Other_____ SSN: _____ - _____- _____ Birth-date ____/____/_____

Referring Physician:_____

Circle One: Married - Single - Partnered – Widowed Name of Partner/Spouse/Significant Other _____

Do you have medical Insurance? Circle One: No Yes If yes, please fill in the following information:

Name of Primary Insurance: _____ ID # _____ Group # _____

*Subscriber's Name: _____ *Birth-date: ____/____/____

Insurance Address _____

Name of Secondary Insurance: _____ ID # _____ Group # _____

*Subscriber's Name: _____ *Birth-date: ____/____/____

Insurance Address _____

*This information is required by HIPPA

How would you like to be contacted about your results:

☐ TEXT Cell number: _____

☐ CALL Cell Number: _____ OK to leave a voice message? YES or NO

Assignment of Insurance Benefits

I, the undersigned, hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my provider to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and even claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

I _____ hereby authorize_____
(Name of Insured) (Name of Insurance Company)

to pay and hereby assign directly to Louisville Lifestyle Medicine all benefits, if any, otherwise payable to me for his/her services as described on the attached forms. **I understand I am financially responsible for charges incurred**. I further acknowledge that any insurance benefits, when received by and paid to Louisville Lifestyle Medicine will be credited to my account, in accordance with the above said assignment.

_____ _____
Authorized Signature of Subscriber Date

Email Policy

I authorize the use of _____, my email address, as a form of correspondence of my medical information and test results with Louisville Lifestyle Medicine's providers. I may cancel the use of this email address for correspondence of my medical information at any time by giving written notice to the address listed below.

_____ _____

Signature of Patient/Legal Guardian Date

Consent for Treatment

I voluntarily consent and authorize Louisville Lifestyle Medicine ("LLM") to conduct collection, testing, and analysis for the purposes of a COVID-19 diagnostic test. I acknowledge and understand that my COVID-19 diagnostic test will require the collection of an appropriate sample by my healthcare provider through a nasal. I understand that there are risks and benefits associated with undergoing a diagnostic test for COVID-19 and there may be a potential for false positive or false negative test results. I assume complete and full responsibility to take appropriate action with regards to my test results. Should I have question or concerns regarding my results, or a worsening of my condition, I shall promptly seek advice and treatment from an appropriate medical provider.

_____ _____

Signature of Patient/Legal Guardian Date

Medicare Authorization
IF YOU ARE COVERED BY MEDICARE, PLEASE SIGN AND DATE BELOW

I request payment of authorized Medicare benefits be made either to me or on my behalf to Louisville Lifestyle Medicine for any services furnished to me by LLM. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the health care provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services, Co-Insurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Signature of Beneficiary Date