URGENT CARE CENTER OF LONGWOOD

450 W State Rd 434 Ste # 1010 Longwood, FL 32750
Ph: 407-212-3000 Fax: 407-212-3001

COVID-19 Self Pay Registration Form

Date: ________

Name: ______________________________ Sex: Female ______________

Date of Birth: ______________________________ SSN: ______________

Driver's License Number: ______________ State Issued: ______________

Address: ____

City: ______________ State: ______________ Zip: ______________

Telephone Number: ______________________________

LAST DATE TESTED FOR COVID-19 ______________ **RESULTS: (...) Positive (...) Negative**

Have you been vaccinated? (...) Yes (...) No **Date** ______________________

Do you currently have or recently had? (...) Fever/Chills (...) Cough (...) Shortness of breath or difficulty breathing (...) fatigue (...) Muscle or Body aches (...) Headache (...) New loss of taste or smell (...) Sore throat (...) Congestion or running nose (...) Nausea or vomiting (...) Diarrhea (...) **EXPOSURE TO COVID-19**

I HEREBY Authorize Longwood Medical Group, dba Urgent Care of Longwood to release any information required to process my claim. I do not have any type of health insurance. If the claim is not paid, I will be responsible for $150 to Urgent Care of Longwood. By signing below, you agree that information provided is accurate and also give permission to Urgent Care Center of Longwood to treat you.

______________ Below for Office Use Only ______________

I was tested for COVID-19 with a Rapid Antigen Test Cassette and the results was:

(...) **Positive** **Test performed by:** ______________

(...) **Negative** **Test performed by:** ______________

(...) **A Nasopharyngeal specimen was collected, sent to Patients Choice Lab, Vista Lab, AVERO Lab or Quest Diagnostic Laboratory for confirmation testing and I was given the information to go online to obtain my results.**

(...) **I declined nasal/oral swab testing.**

(...) **I have been advised to self-quarantine for 14 days and follow up for re-testing.**

Patient Signature: ______________________ Date: ______________