PANCARE OF FLORIDA, INC.

CORONAVIRUS TESTING INTAKE FORM

PATIENT INFORMATION

Last Name | **First Name** | **Middle Initial**

Social Security Number | **Date of Birth** | **U.S. Military Service (☑ one):** ☐ None ☐ Currently Serving ☐ Discharged

Address | **City** | **State** | **Zip Code** | **County**

Home Phone ( )	**Work Phone** ( )	**Cell Phone** ( )	**Email**

Marital Status (☑ one): ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Primary Language Spoken: ☐ Limited English

Patient's Relationship to Responsible Party (☑ one): ☐ Self ☐ Spouse ☐ Natural Child ☐ Parent ☐ Foster Child ☐ Foster Parent

Gender (☑ one): ☐ Female ☐ Male ☐ Transgender Male/Female-to-Male ☐ Transgender Female/Male-to-Female ☐ Other ☐ Choose Not To Disclose

Sexual Orientation (☑ one): ☐ Choose Not To Disclose ☐ Lesbian or Gay ☐ Straight (not lesbian or gay) ☐ Bisexual ☐ Something Else ☐ Don't Know

Race (☑ one): ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian ☐ Other Pacific Islander ☐ White ☐ Multiple/Other ☐ Choose Not To Disclose

Ethnicity (☑ one): ☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Are you a migrant/seasonal worker or a family member of a migrant/seasonal worker? ☐ Yes ☐ No

What is your annual income? ☐ $0-$12,490 ☐ $12,491-$15,614 ☐ $15,615-$18,735 ☐ $18,736-$21,858 ☐ $21,859-$24,980 ☐ $24,981 & UP

Number of people in household:_____

Emergency Contact	**Phone** ( )	**Relationship to Patient**

RESPONSIBLE PARTY INFORMATION (enter name of person *FINANCIALLY* responsible for your account)

Last Name | **First Name** | **Middle Initial**

Mailing Address | **City** | **State** | **Zip Code** | **County**

Home Phone ( )	**Work Phone** ( )	**Cell Phone** ( )	**Date of Birth**	**Social Security Number**

INSURANCE COMPANY – *INCLUDING MEDICAID*

Primary Insurance | **ID#** | **Group #** | **Insurance Company Address**

Name of Insured | **Date of Birth** | **Insured's Employer**

Relationship to Responsible Party: ☐ Self ☐ Spouse ☐ Natural Child ☐ Step Child Parent ☐ Foster Child ☐ Foster Parent

Secondary Insurance | **ID#** | **Group #** | **Insurance Company Address**

Name of Insured | **Date of Birth** | **Insured's Employer**

Relationship to Responsible Party: ☐ Self ☐ Spouse ☐ Natural Child ☐ Step Child Parent ☐ Foster Child ☐ Foster Parent

Assignment and Release: *I authorize my insurance benefits to be paid directly to PanCare Health. I also authorize PanCare Health to release any information required to process this claim.*

SIGNATURE:_____ **DATE:**_____

PANCARE OF FLORIDA, INC.

CORONAVIRUS (COVID-19) TESTING CONSENT

I authorize PanCare of Florida, Inc. (PanCare Health) to conduct collection and testing for COVID-19 through a nasopharyngeal or nasal swab. I understand that my insurance will be billed for this testing.

I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.

I understand that I am not creating a patient relationship with PanCare Health by participating in testing. I understand that PanCare Health is not acting as my medical provider. I assume complete and full responsibility to take appropriate action with regards to my test results.

I understand that a positive test result indicates that the virus was detected and I am currently infected with the virus and presumed to be contagious. A negative test result means that the virus was not present in the specimen above the limit of detection. I understand that, as with any medical test, there is the potential for false positive or false negative test results.

I acknowledge that I have been given a copy of PanCare Heath's Notice of Privacy Practices. I have been informed about the test purpose, procedures, possible benefits and risks. I have been given the opportunity to ask questions before I sign.

I acknowledge that I have read, understand, agree, certify and/or authorize the information above and further agree to hold harmless PanCare Health, including its employees, agents, and contractors from any and all liability and claims.

_____ _____

Signature of Patient/Legal Representative Date

_____

Printed Name of Patient/Legal Representative