COVID 19 Testing Patient Information Sheet

To ensure your safety testing is done by appointment. Call 630-357-1030.

Thank you for choosing our office. In order to properly serve you please complete this form. Print your answers.
A physical exam is recommended for every child tested since COVID symptoms are similar to FLU, Strep Throat and common colds. Check here ❒ if you want your child examined by our physicians and tested for other illnesses.

PATIENT(S) to be tested – List yourself and then any household member who is also being tested. Enter the phone number of any person using a different number than listed in first space. If not, leave blank.

Full Name (First, MI, Last)	**Date of Birth** MM/DD/YYYY	**Sex** M/F/O	**Phone** (Area code and number)	**Leave Blank**

PATIENT(S) Demographics – print your complete address and circle your answers.

Current Mailing Address (Number and Street) City State Zip code

Race (pick one) ☐ African American ☐ American Indian ☐ Asian ☐ Caucasian ☐ Pacific Islander/Alaskan ☐ Other

Ethnicity (pick one.) ☐ Hispanic ☐ Non-Hispanic

PAYMENT INFORMATION

Do you have medical insurance? ☐ Yes ☐ No If Yes, does your insurance company participate with us? ☐ Yes ☐ No
Please *note*: we are not able to file insurance claims to every company. As a pediatric office, we cannot accept Medicare. If not using insurance, our out of pocket charge for a COVID19 Rapid Antigen Test is $60 payable by cash or credit card at the time of service. To use insurance, you must present your insurance card at the time of testing or provide a copy of the back and front of the card.

If using insurance, complete this section.

1. I authorize this office to release any information necessary to process insurance claims.
2. I understand that I am responsible for all charges, regardless of insurance coverage.
3. I hereby assign payment of medical insurance benefits to Naperville Pediatric Associates.
4. I authorize the release of a copy of this authorization to be used in place of the original.
5. **I certify that the above information is correct.**

Signature Date Relation to Patient(s)

Consent for Treatment Must be signed and dated

I consent to COVID 19 rapid antigen testing by swabbing my nostrils with a Dacron tip test swab performed by the attending physician or his/her assistant or designee as may be necessary in his/her best medical judgment.

Signature Date Relation to Patient(s)

Phone to call _____Date of testing _____ Needs a paper result: Yes No

After completing this form, print and bring it with you or you can email a pdf copy to pedsprint@hpeprint.com .