Insurance______________ Cash $____________ Credit Card $____________ Self Pay $______________

Insurance ID: __________________________ Group Number: _____________________________________

CWFM COVID-19 DRIVE THROUGH DEMOGRAPHICS

Name: _______________________________ Birthdate: _____________ Age: __________ Sex: M / F

Address: ____ County: _____________________

City: ___________________ State: ____________ Zip code: _______________Phone number: ______________________

Email: ____

Doctor/PA/FNP: _________________________ Did you complete your telehealth visit today? YES NO

Circle the test you are having today. **Rapid Covid/Flu** (same day) **PCR** (send out 24-48hour) **STREP** **FLU**

- Is this your first Covid-19 test? YES NO
- If no, have you ever had a positive? YES NO
  - If YES, when was your first positive? ____________
- Are you employed in healthcare? YES NO
- Are you symptomatic as defined by the Center for Disease Control (CDC)? YES NO
  - Fever Cough Shortness of breath Sore throat
  - If YES, when did your symptoms start? ____________________
- Have you ever been hospitalized with Covid-19? YES NO
- If yes, were you in ICU? YES NO
- Have you had close contact with a person known to be positive for COVID? YES NO
  - If YES, what was the date of exposure? ____________________________
- Are you a resident in congregate care setting (nursing home, group home, psychiatric treatment facility, or foster care)? YES NO
- Did you receive the COVID-19 Vaccine? YES NO
  - If YES, when? ____

By signing this form and consenting to testing, you are giving Conroe Willis Family Medicine consent to treat your healthcare needs according to Covid-19 results.

X____ ______________________

Patient or legal guardian Date

FOR OFFICE USE ONLY: DATE OF SERVICE: __________________Tech: _______________OPERATOR: ________________

COVID:	positive	negative
FLU A:	positive	negative
FLU B:	positive	negative
STREP:	positive	negative
RSV:	positive	negative

Alliance: ____________ Quest: _____________

11806 Barker Cypress Rd., Cypress, TX 77433
Phone: 832.220.7193
Fax: 888.244.5892

CLIA: 45D2101155

Ordering Provider

Conroe-Willis Family Medicine

4015 Interstate 45 N Suite 220, Conroe, TX 77304

ICD-10 Codes

- O Z03.818 Encounter for Observa on for suspected exposure (Concern about a possible exposure to COVID-19)
- O Z20.828 Contact with and (suspected) exposure– (Actual exposure to someone who is confirmed or suspected (not ruled out) to have COVID-19, and the exposed individual either tests nega ve or the test results are unknown)
- O Z11.59 Asymptoma c individuals who are being screened for COVID-19 and have no known exposure to the virus, and the test results are either unknown or nega ve
- O R05-Cough
- O R06.02 Shortr ess of Breath
- O R50.9 Fever
- O R43.0 Anosmia (loss of smell)
- O U07.1 Confirmed posi ve test for Covid-19

Pa ent Informa on (Completely fill in the pa ent demographics) O Insurance O Bill Referring Provider: ____________

* Last Name: ____________ * Phone Number: ____________ * Policy Name: ____________
* First Name: ____________ *Address: ____________ * Member ID: ____________
* Date of Birth: ____________ * City & State: ____________ * Relationship to Policy Holder: O Self O Dependent
Email: ____________ *Zip Code: ____________ * Policy Holder Name: ____________
*Gender: O Male O Female *County: ____________ *Policy Holder Date of Birth: ____________

*Race
O American Indian or Alaska Native O Black or African American O White
O Asian O Native Hawaiian or Other Pacific Islander O Other O Unknown

*Ethnicity O Hispanic O Non-Hispanic O Unknown

Ques onnaire ☐ Symptoma c ☐ Asymptoma c

Travel to a High Risk respiratory illness region in the past O Yes O No O Unknown

Had Close* contact with person (s) known to have communicable illness been reported? O Yes O No O Unknown

**Close contact is defined as persons within approximately 6 (2 meters) or within the room or care area of a pa ent(s) with confirmed or probable illness*

Travel or close contact (if applicable) occur within 14 days of symptoms onset O Yes O No O Unknown

Check all that apply below

- O Fever Present
- O Cough
- O Shortness of breath
- O Sore Throat

Symptoms Onset Date: ____________

Future Accession: ____________
Collectors Initials: ____________
Collection Date: ____________
Collection Time: ____________

I understand that responsibility for payment for services provided by MedTech Laboratory Services, LLC for myself or my dependents is my personal responsibility en rely, whether I have healthcare insurance coverage or not. I understand that if I have healthcare insurance it is my personal responsibility to verify coverage and/or benefits regarding all services provided by MedTech Laboratory Services, LLC prior to receiving services. I agree that I am responsible to pay 100% of the provider's actual charges. In addi on, I agree to pay interest of 1% monthly (12% annually) and a one- me delinquency fee equal to 25% of the past due balance. I also agree to pay court costs and a orney fees as may be required to effect collec on of any past due balance.

The Informa on provided on this form and on the specimen collec on device is accurate. I acknowledge that Medtech Laboratory Services, LLC may be an out of network provider with my insurer. I am also aware that in some cases my insurer may send the payment directly to me; if that happens, I agree to endorse the check to Medtech Laboratory Services within 5 days. I understand that Medtech Laboratory Services, LLC may use my specimen and any tes ng performed on that specimen for research development and poten al publica on purposes as long as the informa on has been properly deiden fied pursuant to applicable law.

Pa ent/Guardian Signature: ____________ **Date:** ____________

The diagnosis codes provided on this form do not represent an exclusive list of appropriate ICD codes. Our Company does not intend to imply that these codes should be used. The provider is responsible for determining the medical necessity of laboratory tests and for assigning and providing the specific ICD code(s) to support the medical necessity of all clinical laboratory tests.

Physician Name: ____________

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