483 East County Line Rd.
Hatboro, PA 19040

SARS-COV-2 COVID-19 DNA/RNA Testing Consent

Legal Name: _____ Chosen Name: _____

Home Mailing Address: _____

City/State/Zip: _____

Phone Number To Receive My Test Result: (_____)_____-_____ Date of Birth: ____/____/_____

Primary Insurance Carrier: _____ Insurance Policy ID#: _____

Please carefully read the following informed consent. By signing the bottom of next page you agree to each of the following statements:

a. I am requesting that Hatboro Pediatrics, PC (the "Practice") perform a COVID-19 test (the "Test") by performing a nasal swab. I am not a patient of the Practice, though my child(ren) is/are.

b. I understand there may be some discomfort when the Practice performs the Test. If the discomfort persists, increases, or I determine that the discomfort is not tolerable, I am fully responsible for obtaining follow-up medical care from a provider other than the Practice and I am responsible for any/all associated costs for this follow-up.

c. I understand that Test results will be communicated to me by the Practice using the phone number I provided above.

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

e. I understand that I may be contacted by a governmental health authority to discuss a positive Test result.

f. I understand that a positive Test result will require me to and I will fully and completely comply with all restrictions and guidance on preventing the further spread of COVID-19 provided by a governmental health authority.

g. I understand that by virtue of having the Practice administer me a Test that I am not creating a physician/patient relationship with the Practice. The Practice will retain a copy of this Consent and your Test results. I will seek medical advice, care and treatment from my medical provider if I have any questions or concerns.

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h. I understand that, as with any medical test, there is the potential for false positive or false negative test results to occur, and that my Test result may not be accurate for a variety of reasons, including but not limited to, my sample being taken too early in the course of a Covid-19 infection (for false negatives).

i. I understand that the Practice's responsibility is solely to collect and process the Test sample, and that the Practice is not responsible in any way for the Test itself, including but not limited to, its design and/or manufacture, and the Practice makes no independent claims about its capabilities, accuracy, efficacy or reliability.

j. I agree to indemnify and hold harmless the Practice and its owner, providers and staff, against any and all claims, suits, or actions of any kind whatsoever for liability, damages, compensation, or otherwise brought by me or anyone on my behalf, including the Practice's attorneys' fees and any related costs, if litigation arises pursuant to any claims made by me or by anyone else acting on my behalf as it relates to the subject matter of this informed consent and receipt of the Test.

k. I acknowledge, understand, appreciate, and agree that the Practice administering me this Test may result in my exposure to COVID-19 and all of its health risks. While the Practice is taking reasonable steps to reduce this risk, I am assuming and accept all known and unknown risks of exposure to COVID-19 by having the Practice administer the Test.

l. I understand the administration fee payable to the Practice for the Test is Fifty Dollars ($50.00) which is non-refundable and which must be paid to the Practice before the Test is administered.

m. I understand the Practice is sending my Test to Medical Diagnostic Laboratories, L.L.C, and Medical Diagnostic Laboratories, L.L.C may bill me for this Test if my insurance does not cover the cost for the Test.

n. I understand there are locations that perform COVID-19 testing at no cost and I am voluntarily choosing to have the Practice perform the Test.

I, the undersigned, have been informed about the Test, the purpose of the Test, and its benefits and risks. I have been given the opportunity to ask questions before I sign. I voluntarily agree to take the Test.

Signature: _____ Date: ____/____/_____

Witness to Signature: _____ Date: ____/____/_____