BetterHealth Pharmacy

COVID-19 Antibody Testing: Informed Consent

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Section 1: Patient Information

First Name:	Middle Initial:		Last Name:
Date of Birth (mm/dd/yyyy):		Phone Number:	
Address:			
City:	State:	Zip:	
Gender: ☐ Male ☐ Female ☐ Other ☐ Unknown			
Do you have any known drug allergies?	☐ Yes ☐ No	Allergies:	
I have been symptom-free for 14 days. Our goal is to help you determine if you have already had exposure to COVID19. Nasal pharyngeal swabs remain the best choice for testing active infections. Testing antibodies during acute illness can produce test results that do not further inform your treatment plan, and you will be asked to re-test in 7-14 days. Antibodies are not detectable by this test until at least 7 days post infection. Coming to us for testing with a recent infection will not inform your diagnosis or treatment, and may put our providers at risk.			☐ Yes ☐ No

Please carefully read and sign the following Informed Consent:

A. I authorize this COVID-19 testing unit to conduct collection and testing for COVID-19 antibodies through a blood-based fingerstick test. I understand and consent to the drawing of a blood sample for the purpose of medical treatment. I understand that the risks involved with blood draws include, but are not limited to, discomfort at the site of the blood draw, possible bruising, redness and swelling around the site, bleeding at the sight, feeling of lightheadedness when blood is being drawn, and rarely, an infection at the site of the blood draw.
B. I understand that antibodies (a positive test result) does not excuse me from state mandates and social responsibilities. Everyone, regardless of antibody status, should continue to follow rules and regulations regarding shelter-in-place, social distancing, and wearing face masks.
C. I understand that information about my results (not including any identifying data) may be compiled by Better Health Pharmacy to establish local trends. This information may be shared with public health officials and community leaders.
D. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.
E. I understand the testing unit is not acting as my medical provider, this testing does not replace treatment by my medical provider, and I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if my condition worsens.
F. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.
G. I understand and agree that I am financially responsible for all charges for any and all services rendered. This includes any medical service or visit, testing and any other screening ordered by the provider or staff.
H. I understand that while my insurance may confirm my benefits, confirmation of benefits is not a guarantee of payment and that I am responsible for any unpaid balance.
I. If I am a Medicare patient, I understand that I need to provide the office both my Medicare ID card and my secondary ID card. If the office does not have the proper information for a secondary insurance, the secondary will not be billed. It will be my responsibility to pay the balance and then file a claim with the secondary for reimbursement.
J. By signing this form, I consent to the use and disclosure of protected health information about me for treatment, payment and health care operations, and/or as required by law. I have the right to revoke this Consent, in writing, signed by me. However, such revocation shall not affect any disclosures already made in compliance with my prior Consent. Better Health Pharmacy's notice of privacy practices can be found at www.betterhealthfw.com/forms.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this Informed Consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask additional questions at any time. I voluntarily agree to this testing for COVID-19 Antibody.

_____ Name of Patient (please print):	_____ Signature of Patient or Guardian:	_____ Date
If you have signed this form as a legally authorized representative of the patient, please identify your relationship to the patient below. (parent, guardian, etc.) _____		