



Better Health Pharmacy  
 8615 S Hulen St #115  
 Fort Worth, TX 76123  
 (682) 708-3499  
[www.betterhealthfw.com](http://www.betterhealthfw.com)

## COVID-19 Testing: Informed Consent

For Pharmacy Use			
RX: _____	<input type="checkbox"/> BDV	<input type="checkbox"/> LUC	
<input type="checkbox"/> POS	<input type="checkbox"/> NEG	<input type="checkbox"/> ACC	<input type="checkbox"/> CARE
<input type="checkbox"/> Billed	<input type="checkbox"/> Reporting		

### Section 1: Patient Information

First Name:	Middle Initial:	Last Name:	
Date of Birth (mm/dd/yyyy):		Phone Number:	
Address:			
City:	State:	Zip:	County:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other <input type="checkbox"/> Unknown		Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic <input type="checkbox"/> Unknown	
Race: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> Native Hawaiian or Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Unknown			
Reason for Testing: <input type="checkbox"/> Asymptomatic, no known exposure; for screening purposes only <input type="checkbox"/> Possible exposure to COVID-19 <input type="checkbox"/> Contact with COVID-19, suspected exposure <input type="checkbox"/> Having symptoms, such as cough, sore throat, loss of smell/taste, etc.			
Do you have any known drug allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please list:			

Please carefully read and sign the following Informed Consent:

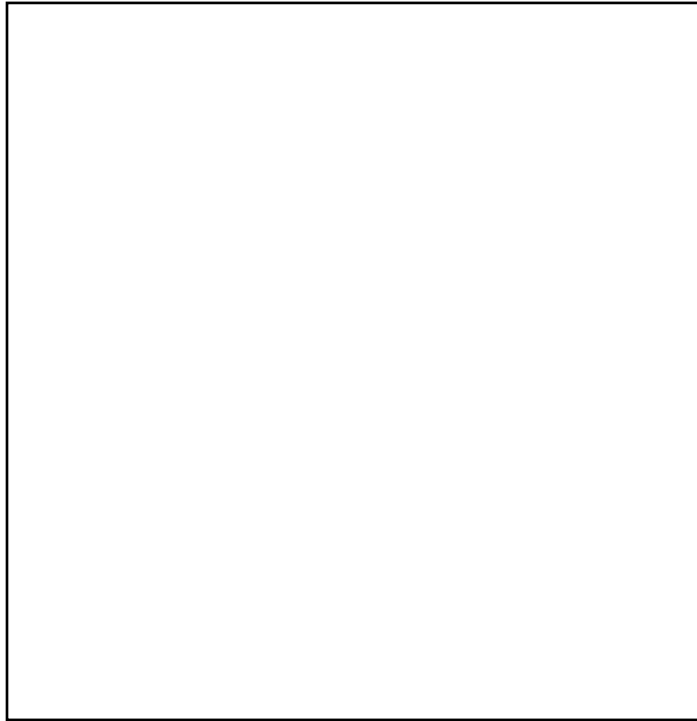
- A. I authorize this COVID-19 testing unit to conduct collection and testing for COVID-19 through a nasopharyngeal swab or blood draw, as ordered by an authorized medical provider or public health official.
- B. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law.
- C. I acknowledge that a positive test result is an indication that I must self-isolate and/or wear a mask or face covering as directed in an effort to avoid infecting others.
- D. 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.
- E. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.

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.

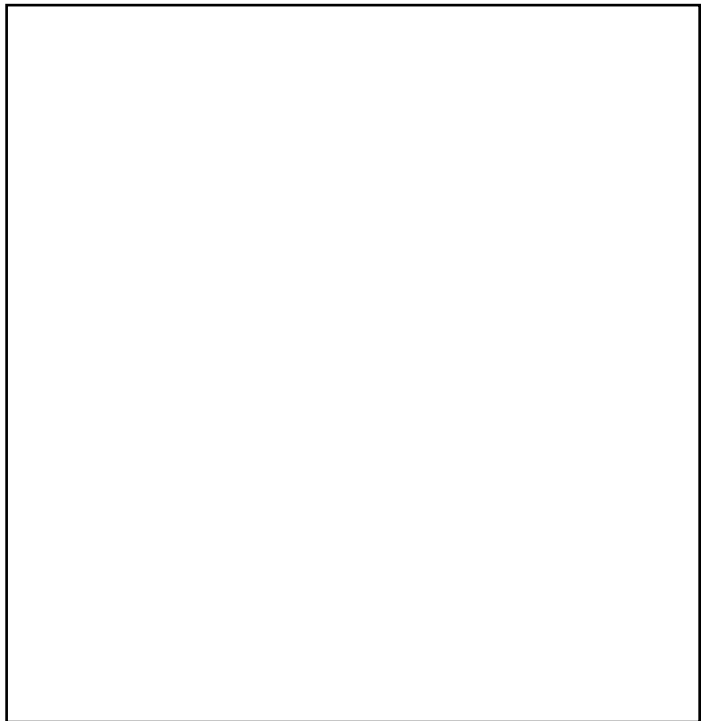
_____ Name of Patient (please print):	_____ Signature of Patient or Guardian:	_____ Date
If you have signed this form as a legally authorized representative of the patient, please identify your relationship to the patient below. (parent, guardian, etc.) _____		

**Insurance Information**

**FRONT Health Insurance**



**BACK Health Insurance**



**FRONT Prescription Insurance**



**BACK Prescription Insurance**

