BetterHealth Pharmacy

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

COVID-19 Testing: Informed Consent

For Pharmacy Use Only

☐ BDV ☐ LUC
☐ POS ☐ NEG ☐ ACC ☐ CARE
☐ Billed ☐ Reporting ☐ INDIC

Section 1: Patient Information

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

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.) _____