



Informed Consent – Rapid Covid-19 Test

This consent form is designed to inform you and to help you better understand the cost of this service. Please understand that this will not be submitted to your insurance and that you are financially responsible for the cost of this service. A 20% discount is available if paid in full at the time of service.

| CPT | Service | Fee |
|-------|----------------------------|------|
| 87426 | SARS-CoV Coronavirus AG IA | \$75 |

- I authorize Capital Area Pediatrics to conduct collection and testing for COVID-19 through a nasal or nasopharyngeal swab as ordered by the physician or nurse practitioner
- I authorize my test results or my child’s test results to be disclosed to the county, state, or to any other governmental entity as may be required by law
- I acknowledge that a positive test result is an indication that I or my child must self-isolate as directed
- I understand that ,as with any medical test, there is the potential for a false positive or false negative COVID-19 test result
- I understand that the out of pocket cost for this testing will not be billed to my insurance and that I agree to be financially liable

I, acknowledge that I have read, understand and agree to the statements contained in this form. I have been informed about the purpose of the test to be performed, potential risks and benefits, and associated costs. I have been given the opportunity to ask questions before proceeding with the testing. I voluntarily consent to Covid-19 testing.

Date:

| | | |
|-------------------------|-------------------------|--------------------------|
| Signature of Guarantor: | Guarantor Name (Print): | Relationship to Patient: |
| | | |