AdventHealth

COVID 19 TESTING CONSENT FORM

I. **CONSENT FOR TESTING**:

1. Consent. I consent to be tested for COVID-19 (“Services”) by AdventHealth and by physicians (“Physicians”), and other medical professionals, residents, students and AdventHealth employees and personnel (collectively “Care Providers”). AdventHealth operates a number of facilities including, but not limited to, hospitals, labs, outpatient centers, medical groups, and Centra Care locations (referred to as a group as “AdventHealth”). Many of these are separate legal entities, but they share certain functions. The list of AdventHealth’s entities is available upon request from AdventHealth.

2. Testing. I understand there are several ways to test for COVID-19. I may be asked to give a saliva or blood sample or receive a nasopharyngeal or oropharyngeal swab to collect secretions. I voluntarily consent to providing any of these samples in order to receive Services. For the saliva sample, I understand I will be asked to spit in a cup or other receptacle. For the nasopharyngeal (nose) or oropharyngeal (throat) swab sample, I understand that a Care Provider will gently insert a small swab with a soft tip into my nostril or down my throat. They will guide it to the back of my nose or throat and twirl it a few times to collect secretions. I understand I may gag a little and may also feel some pressure or discomfort. For the blood sample, I understand that the procedure to be performed is called a venipuncture which involves inserting a needle into one of my veins from which approximately 5-10cc of blood (or about 2-3 tablespoons or less) will be drawn. I understand that I may experience mild discomfort or pain from the needle puncture and possible bruising or mild bleeding, and that I may also feel dizzy or faint. There is also a slight risk of infection at the site of the draw, the risk, I have been told, can be reduced by keeping the puncture site clean and dry. I understand that any tissues, specimens or fluids obtained from me during my care may be disposed of by AdventHealth and/or examined, documented and/or preserved for purposes of (i) aiding in my diagnosis/treatment; and/or (ii) fostering the advancement of medical knowledge, including medical research where authorized by law.

3. Acknowledgement of Risks. I fully acknowledge any and all risks and benefits involved. I understand that the Services today will result in lab work being sent to my electronic medical record and to my primary care physician. I acknowledge that it is my responsibility to receive results from my primary care physician or medical records department of the AdventHealth facility where I received Services and that laboratory personnel are not authorized to give test results to patients.

II. **CONSENT FOR PAYMENT**:

1. Waiver of Copays and Deductibles. I understand that copays and deductibles are waived for the Services.

2. Insurance Payments and Assignment of Benefits. To the extent permitted by law and if I am entitled to benefits under: (i) the Medicare program, the Medicaid program, other kinds of government insurance (the “Program”); or (ii) any insurance policy or other health benefit plan (covering me or anyone legally responsible for me) or from any other source (the “Benefit Plan”), including as a result of injuries sustained by me, in consideration for admission to and/or for Services provided to me by AdventHealth, Physicians and Care Providers, which includes independent contractors, I irrevocably assign, transfer and convey the Program and Benefit Plan benefits payable and all right, title and interest in and to such benefits, compensation or payment received or to be received for the Services provided to me by AdventHealth, Physicians and Care Providers (collectively “Benefits”) to AdventHealth, Physicians, Care Providers, and their assignees. I irrevocably authorize payment of my Benefits directly to AdventHealth, Physicians, Care Providers and their assignees, to be applied to paying for my Services.

If my Benefits are provided under a self-funded/insured plan under the Employee Retirement Income Security Act - (ERISA) or other type of Benefit Plan, in order to assist me in getting my Benefits: I irrevocably authorize and appoint AdventHealth, Physicians, Care Providers or their assignees to be my representative and attorney-in-fact, when AdventHealth, Physicians, Care Providers or their assignees consent in writing to so act in taking all actions necessary to receive payment, appealing any adverse benefit determination or requesting any reconsideration and to receive notices on my behalf for this purpose. I will comply with procedures established by ERISA or my Benefit Plan relating to this authorization, if any.

I agree to help AdventHealth, Physicians and Care Providers or their assignees receive payments as reasonably needed and authorize AdventHealth, Physicians and Care Providers and their assignees to take reasonable actions to seek payment for the Services.
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3. Honesty Statement. I certify the information I have given (i) about my Benefits coverage or other payment sources and (ii) in applying for payment under Medicare and Medicaid is true and correct to the best of my knowledge.

4. Credit Report Consent. I authorize AdventHealth, Physicians and Care Providers, or their assignees, to obtain credit reports about my credit history from one or more credit reporting agencies at any time about: (i) past, current or anticipated Services (whether or not such Service did, may, or will involve an extension of credit); or (ii) an outstanding Account balance.

III. **CONSENT TO CONTACT**:

I consent to allowing AdventHealth, Physicians and Care Providers and their independent contractors, agents and assignees to contact me by texting or calling and leaving messages on my answering machine or in voice mail, using any wireless or cellular numbers, land lines, or electronic mail addresses that I have given to AdventHealth for this drive by testing, for any purpose related to my care, including test results and appointments, or services and products offered by AdventHealth.

IV. **CONSENT TO SHARING HEALTH INFORMATION**:

I give consent to AdventHealth, Physicians and Care Providers to share the following information as permitted by law and explained below:

a. What Information: My health information and Highly Confidential Information. **HIGHLY CONFIDENTIAL INFORMATION INCLUDES SUBSTANCE ABUSE, MENTAL HEALTH, HIV/AIDS, RAPE/SEXUAL ASSAULT, GENETIC TESTING, VENEREAL DISEASE, SICKLE CELL ANEMIA, FAMILY PLANNING, ABORTION, AND HOSPICE INFORMATION, AS WELL AS INFORMATION IDENTIFIED IN THE JOINT NOTICE OF PRIVACY PRACTICES AS SUBJECT TO SPECIAL STATE LAWS.**

b. For What Purposes: Treatment, payment, and healthcare operations and as further described in the AdventHealth Joint Notice of Privacy Practices.

c. To Whom:

- Any person or entity responsible for (i) paying for or determining if I am eligible for payment for my treatment or for assigning my Benefits, and (ii) their healthcare operations.
- Physicians or Care Providers or my referring physician and any health care practitioner, nursing home, health care facility, ambulance service, home health agency, hospice, government or private agency which may provide medical, mental health, rehabilitation, social or related Services to me during a visit with, or during or upon my discharge or transfer from an AdventHealth facility.
- Physicians who have not treated me at AdventHealth but have my written permission to access my health information.
- Business partners of AdventHealth, Physicians or Care Providers who provide administrative, operational, financial, legal and technical support services.
- AdventHealth's affiliates, which are other entities owned or managed by AdventHealth or other physicians who are participating in integrated physician or plan networks.
- AdventHealth's institutionally related foundation for fundraising purposes, but only my name, address, contact information, age, gender, dates of services, health insurance status, department where services were provided, treating physician(s), and outcome information.

d. How Will It Be Shared: Email, facsimile, hand delivery, electronic medical records and health information exchanges. Health information exchanges are entities that store and/or transfer health information electronically among providers for continuity of care. This consent means that AdventHealth, Physicians and Care Providers may access my health information and Highly Confidential Information through health information exchanges and share my health information and Highly Confidential Information with other health care providers through health information exchanges.

e. Can I Stop Sharing My Health Information: Please review the Joint Notice of Privacy Practices and ask AdventHealth for the Request to Restrict Use and Disclosure of Protected Health Information form.

DATE/TIME: ___________ Signature: ____

IF THE SIGNATURE ABOVE IS NOT THE PATIENT'S, INDICATE BELOW THE RELATIONSHIP OF THE PERSON SIGNING FOR THE PATIENT AND THE REASON THE PATIENT IS NOT ABLE TO SIGN.

Relationship: __________________________ Printed Name: ____

(E.G., Parent, Guardian or Authorized Representative, Guarantor)

DATE/TIME: ___________ Signature: ____

Printed Name: ____