K.K. Bhatia, M.D., F.A.A.P.

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COVID-19 TESTING INFORMED CONSENT FORM

Parent/Guardian:_____ Relation:_____

Patient Name:_____ DOB_____

Phone Number: _____ alt. # _____

Informed Consent: Please carefully read the following informed consent:

a. I authorize Dr K K Bhatia to perform a rapid Covid-19 test.

b. I authorize my test results to be disclosed to the county, state, or to any other government entity as may be required by law.

c. I acknowledge that a positive test result is an indication that I must self-isolate and wear a mask covering as directed in effort to avoid infecting others. If positive, I will be contact by the local public health department.

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 consume complete and full responsibility to take action with regards to my test results. I agree I will seek medical advise, care and treatment from my medical provider if I have questions or concerns, or if my condtion worsens.

e. I am aware how Covid-19 spreads and I understand that I am potentially putting myself/child at risk by being out of the house and in my office for Covid-19 testing. K K Bhatia is not responsible for any exposure while in office.

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. In addition, I have been given a copy of instructions of what I have to do following testing, I have read those discharge instructions thoroughly, and I agree to comply with those instructions.

h. I agree that K K Bhatia does not accept billing of insurance for the Covid-19 Rapid Test and I understand that there is a flat fee of $100 due before testing is performed. I understand that it is my choice to go to a center that offers free PCR testing or another office that will bill insurance for testing.

Parent/Guardian Signature: _____ Date:_____

Witness: _____ Date:_____