SAVING LIVES CENTER FAMILY CLINIC & URGENT CARE
3 HILLCREST DRIVE SUITE A101
FREDERICK, MARYLAND 21703
TEL: 240-575-9940, FAX: 240-575-9481

Patient Information Sheet

Date: _____

NAME: Last _____ **First** _____ **MI** _____

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____

DATE OF BIRTH _____ **Gender: (circle one)** **Female** **Male**

RACE: (Please circle one) **CAUCASIAN** **AFRICAN AMERICAN** **HISPANIC** **OTHER**_____
INDIAN **NATIVE ANERICAN** **ASIAN**

SOCIAL SECURITY Number (Adult Patient or Guarantor's SS#) _____**(MANDATORY for VA, TRICARE Medicaid and Medicare Patient)**

PHONE: CELL (_____) _____- _____ **Home** (_____) _____- _____

Email Address: _____

Emergency Phone Contact Name and phone number: _____

How did you hear about us? _____

I acknowledge that all information supplied by myself to Saving Lives Center Family Clinic & Urgent Care is true and correct: _____ (**Patient Initials**)

INFORMED CONSENT FOR COVID-19 TESTING

1. **Authorization and Consent for Covid-19 Testing:**

I voluntarily consent and authorize Saving Lives Center Family Clinic ("SLCFC") to conduct collection, testing, and analysis for the purposes of a COVID-19 diagnostic test. I acknowledge and understand that my COVID-19 test will require the collectionof an appropriate sample by healthcare associates/provider through a nasopharyngeal swab, oral swab, finger prick, or other recommended collection procedures. I understand that there are risks and benefits associated with undergoing a test for COVID-19 and there may be a potential for falsepositive or false negative test results. I assume complete and full responsibility to take appropriate action with regards to my test results. Should I have question or concerns regarding my results, or a worsening of my condition, I shall promptly seek advice and treatment from an appropriate medical provider.

2. **Patient Rights and Privacy Practices**

a) Notice of Privacy Practices and Patient Rights: SLCFC's Notice of Privacy Practices describes how it may use and disclose your protected health information to carry out treatment, initiate and obtain payment, conduct health care operations and for other purposes that are permitted or required by law.

b) Disclosure to Government Authorities: I acknowledge and agree that SLCFC may disclose my test results and associated information to appropriate county, state, or other governmental and regulatory entities as may be permitted by law.

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Release

To the fullest extent permitted by law, I hereby release, discharge and hold harmless, SLCFC, including, without limitation, any its respective officers, directors, employees, representatives and agents from any and all claims, liability, and damages, of whatever kind ornature, arising out of or in connection with any act or omission relating to my COVID-19 diagnostic test or the disclosure of my COVID-19 test results.
By selecting the ACKNOWLEDGEMENT during the registration process for COVID-19 Testing at SLCFC, I acknowledge and agree that I have read, understand, and agreed tothe statements contained within this form. I have been informed about the purpose of the COVID-19 test, procedures to be performed, potential risks and benefits, and associated costs. I have been provided an opportunity to ask questions before proceeding with a COVID-19 test and I understand that if I do not wish to continue with the collection, testing, or analysis of a COVID-19 test, I may decline to receive continued services.
I have read the contents of this form in its entirety and voluntarily consent to undergo testing for COVID-19.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party(please print) Relationship to Patient

Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment. **THIS IS FOR ALL INSURANCE including Medicare and Medicaid**

- **Please understand that payment of your bill is considered part of your treatment. Fees are payable** before services are rendered. We accept cash, credit cards, debit cards and pre-approved insurance for which we are a contracted provider and are the designated Primary Care Provider (PCP), if applicable. Co-pays/Co-Insurance payment are part of your treatment and all payment made for services are **NOT Refundable**.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company, we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Proof of payment and photo ID are required for all patients. We will ask to make a copy of your

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ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective or that the services rendered will be covered by your insurance company.

- Please understand some insurance coverages have Out-of-Network benefits that have co-insurance charges, higher co-payments and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In-Network rate.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I oblige financial responsibility and pay all such charges in full.

_____ _____

Signature of Patient /Responsible Party Date

_____ _____

Name of Patient/Responsible Party (please print) Relationship to Patient

Medical Insurance Information

Insurance name:	**Policy Holder's Name:**
Policy Holder's Relationship to Patient	
Subscriber OR Member #:	**Group #**
Secondary Insurance If applicable	
Insurance name:	**Policy Holder's Name**
Policy Holder's Relationship to Patient	
Subscriber OR Member #:	**Group #**

For ALL No Health Insurance/uninsured, Not Sure if your Health Insurance will cover the visit with the testing, or Out of State Medicaid (not Maryland Medicaid)

Sign here _____

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Name: _____

Date of Birth: _____ **TODAY'S DATE:** _____

Saving Lives Center Family Clinic COVID-19 SCREENING

PLEASE READ EACH QUESTION CAREFULLY	PLEASE CIRCLE THE ANSWER THAT APPLIES TO YOU	
Have you experienced any of the following symptoms in the past 48 hours: • fever or chills • cough • shortness of breath or difficulty breathing • fatigue • muscle or body aches • headache • new loss of taste or smell • sore throat • congestion or runny nose • nausea or vomiting • diarrhea	**YES**	**NO**
Within the past 14 days, have you been in close physical contact (6 feet or closer for a cumulative total of 15 minutes) with: • Anyone who is known to have laboratory-confirmed COVID-19? OR • Anyone who has any symptoms consistent with COVID-19?	**YES**	**NO**
Are you isolating or quarantining because you may have been exposed to a person with COVID-19 or are worried that you may be sick with COVID-19?	**YES**	**NO**
Are you currently waiting on the results of a COVID-19 test from another facility?	**YES**	**NO**
Have you received your COVID-19 Vaccine? If yes, which one? • Pfizer 1st shot date _____ 2nd shot date given_____ • Moderna 1st shot date given _____ 2nd shot date given _____ • Janssen shot date given _____ • OTHERS_____	**YES**	**NO** **If you would like to take the vaccine please inform us, we have COVID-19 vaccine available at the clinic**

DO NOT WRITE------ FOR CLINIC/MEDICAL STAFF USE ONLY

TIME:

TEMP:	**PULSE/HR:**	**RESP:**	**O2 Saturation:**
Covid-19- Rapid: TRIPLEX	**PCR /URI:**	**STREP:**	**Mono:**

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