South Coast Medical Group Family and Sports Medicine AKA SCMG
COVID-19 RAPID SARS Antigen FIA Consent Form
PATIENT INFORMATION AND PAYMENT INFORMATION

Please complete the following information:

Patient name_____ Date of birth: _____

Patient address_____

Patient phone number_____ Patient Email: _____

Credit Card information (Will be charged $80 at the time of service)

Credit Card# _____ Exp. Date: _____

Are you an Established patient with South Coast Medical Group YES NO

Please carefully read the following informed consent: **a**. I authorize this COVID-19 testing unit to conduct collection and testing for COVID-19 through a **Rapid COVID-19 Antigen test** **b**. As ordered by an authorized medical provider. **c**. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law. **d.** I acknowledge that a positive test result is an indication that I must continue to self-isolate in an effort to avoid infecting others. **e**. I understand that testing does not replace treatment by a medical provider. 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. **f**. I understand that, as with any medical test, there is the potential for false positive or false negative test results can occur. **g.** I voluntarily agree to testing for COVID-19. AGREEMENT FOR SELF-ISOLATION The local health jurisdiction has determined that if you are under suspicion for having COVID-19 due to symptoms and testing request, that it is necessary to be placed in isolation in order to prevent the transmission of this infection. It is important for you to comply with this Isolation Agreement in order to protect the public's health. **h**. **I understand that SCMG only has a cash pay platform for the Rapid COVID-19 Antigen test and that a lab-based PCR test can be performed with an office visit and submitted to my insurance. I am choosing to have the cash pay platform for the in lieu of the lab-based PCR lab through**

My signature below acknowledges that I fully understand the information above (a through h). Additionally, I authorize South Coast Medical Group Family and Sports Medicine to perform the **Rapid COVID-19 Antigen test** ***and authorize the $80 fee to be charged to my credit card.***

_____ _____

Signature Date