Reece School Covid-19 Form

*D.O.B.:______________

*Patient Name:_________________________

*Last Name: ____________________________ * First Name: _____________________________

*Permanent Address: _______________________________________ Apt: _________________

City: _________________________ State: ____________________ Zip Code: ______________

*Home Number: _____________________________ *Cell Number: _________________________

*Email: ____

*Emergency Contact: _____________________ *Relationship to Patient(s): _____________________

*Phone Number: ____

*Pharmacy: ____

DOB: ______________ Social Security:_____-_____-_______ Sex: ❑ Male ❑ Female

PRIMARY INSURANCE INFORMATION:
Insurance: __________________________________ ID Number: _________________________

Group #: ________________ CoPay: ____________ Effective Date: _________________________

SECONDARY INSURANCE INFORMATION:
Insurance: __________________________________ ID Number: _________________________

Group #: ________________ CoPay: ____________ Effective Date: _________________________

Ethnicity:
❑Hispanic/Latin Origin ❑Not of Hispanic/Latin Origin ❑ Decline to State

Race:
❑Asian ❑Black or African American ❑Caucasian ❑ Decline to State

❑Other: ______________________________________

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*HAVE YOU EVER BEEN POSITIVE FOR COVID-19? YES ❑ NO ❑ WHEN? _____/______/________

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*Patient Name:____________________________________

COVID-19 GUARDIAN AUTHORIZATION & CONSENT FORM

COVID-19 Student Consent

Parcare Community Health Network performs Covid-19 drives in the community. This consent provides Parcare Community Health Network with permission to perform a **Covid-19 Nasal Swab** on your child without your attendance. By signing below, you are indicating that you voluntarily consent to allow your child to be tested for the detection of COVID-19 by one of our staff members.

The test being administered involves a nasal swab that will be tested to indicate the potential presence of COVID-19. Your child's swab will be sent to a lab for PCR testing and the lab will report the result to the New York State Department of Health. They will report all negative and positive results.

*Patient's Name ____ *DOB: (mm/dd/yy) ___________________________________

*____
Signed (Patient or Legal Representative for Patient) *Date:____________________________

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Legal Representative's Relationship to Patient

HIPAA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.

*Patient's Name ____ *DOB: (mm/dd/yy) ___________________________________

*____
Signed (Patient or Legal Representative for Patient) *Date:____________________________

____
Legal Representative's Relationship to Patient