MAXEM HEALTH URGENT CARE
PO BOX 1248
OCEAN SPRINGS, MS 39566
Phone: 228-223-1927

RAPID COVID ANTIGEN CONSENT FORM

PATIENT RECEIVING RAPID COVID ANTIGEN TEST INFORMATION

LAST NAME: _____ FIRST NAME: _____ M.I. _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME #: _____ WORK : _____ CELL #: _____

SSN: _____ DATE OF BIRTH: _____

I consent to treatment for myself or above minor child. I understand that the examination and/or medical treatment I will receive is NOT intended to replace complete medical care by my personal primary care physician. I am aware that I will be responsible for full payment at the time of service. My failure to pay may result in collection proceedings and/or late fees. In addition, I authorize Maxem Health Urgent Care to release to my primary care physician or specialty referral any and all information related to my treatment at this clinic.

SIGNATURE OF PATIENT RECEIVING TEST OR PARENT/GUARDIAN: _____

Date: _____

BELOW FOR CLINIC USE

DATE OF TEST: _____

MANUFACTURE/LOT NUMBER: _____

EXPIRATION DATE: _____

SIGNATURE OF PERSON ADMINISTERED TEST: _____

RESULTS: _____