Lab Director: Najmuddin Khaja, Ph D

CLIA #: 45 D 2111111
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PROVIDER INFORMATION

Texas State University
601 University Drive
San Marcos, TX 78666

Faculty/Staff or Student
Circle One

PATIENT INFORMATION

Last Name: ____________________________ First Name: ____________________________ M.I.: ________ ○ Male ○ Female

D.O.B.: _____/_____/______ S.S.N.: _____ - _____ - _____ Height: _____ Weight: _____ Phone #: _____ - _____ - ______ Text? Y or N Circle One

Street Address ____ City _________________ State _________ Zip _________

Insurance Type: (Circle One) Self Pay Commercial Medicare Medicaid CARES ICD-10 Codes: **B34.2, Z20.828,** ________ ________
Circle all that apply

Email: ____________________@txstate.edu **TXST ID:** ____________________

Specimen Collection

____***COVID-19 PCR***

AUTHORIZED HEALTHCARE PROVIDER

I acknowledge to support medical necessity for all tests in the patient's chart.

If not signed, Authorized Health Care Provider affirms that test orders are placed in the patient file with provider signature and will be available upon request. *MD Toxicology Group requires documentation in patient medical chart including date of service, tests ordered and documentation to support necessity.

Authorized Provider Signature:_______________________________

Date:_______________________________

PATIENT AUTHORIZATION

I hereby acknowledge that the specimen provided is my own and has not been adulterated. I authorize MD Diagnostic Labs to analyze the specimen and release the test results to the ordering practitioner. By signing this authorization, I acknowledge that I am financially responsible for all co-pays, deductibles, and any amounts not covered by insurance and I authorize my physician and/or staff to release any information necessary to MD Diagnostic Labs and MD Toxicology Group to determine benefits for laboratory services. If self-pay is selected, I accept full financial responsibility for all payments associated with laboratory services. I acknowledge MD Diagnostic Labs to share my test results with the Texas State University Student Health Center for weekly test reporting.

OR

If CARES ACT is selected above, I certify that I do not have medical insurance. I am financially responsible for any amounts not covered after my test has been taken.

Patient Signature: ______________________________________

Date: ______________________________________

Copies of insurance, if insured, and a copy of a state driver's license is needed. If unable to add to this document, staff can make a copy at the testing site.

Place Front Photo of Insurance Card Here (If Applicable)	**Place Back Photo of Insurance Card Here (If Applicable)**	**Place Front Photo of State ID Card Here**	**Place Back Photo of State ID Card Here**

SPECIMEN COLLECTION

Date: ____/____/____ Time: _______ AM/PM

Collected by: __________________________

Lab Use Only: Name: ________________________________

Date: _____/_____/_____ Initials:

COVID-19 SPECIMEN TESTING WAIVER AND CONSENT

This is an Agreement to receive a COVID-19 PCR Test and/or a COVID-19 Antigen Test. This COVID-19 Specimen Testing Waiver and Consent (this "Consent") sets out the agreement between MD Toxicology Group, LLC ("MDT" or "we"), and you the undersigned individual ("Client" or "you") in connection with administering a test (as defined below).

Coronaviruses are a type of virus. There are many different kinds, and some cause disease. A newly identified coronavirus, SARS-Co V-2, Severe Acute Respiratory Syndrome 2, has caused a worldwide pandemic of respiratory illness, called COVID-19. This virus presents a number of unknown and variable results.

With your consent and on your behalf, we are collecting samples for purposes of applying a test of your choice (a) "COVID-19 PCR Test" which is intended to measure if you have the virus that causes COVID-19. and/or (b) "COVID-19 Antigen Test" which is intended to rapidly assess and provide preliminary results on whether or not you have been currently infected by the COVID-19 virus.

You acknowledge, represent, warrant and covenant to MDT the following responsibilities:

a) You are either (a) at least eighteen (18) years of age or (b) the parent or legal guardian of a person subject to testing.
b) You understand that Test results reported by MDT are based on the determination or diagnosis of our high-complexity lab. These Test results will be reported directly to you via e-mail, text and/or phone call (results portal). You further understand that it is your responsibility to consult your own medical professional for the interpretation, analysis, evaluation, and explanation of your Test results.
c) You understand and agree that Test results will be maintained as confidential, protected health information ("PHI") by MDT as required by federal and state law. You understand that the Test results will become part of your medical record. You understand an insurance company may discover the results of this Test by obtaining a copy of your medical record in accordance with the terms of your insurance policy(ies).
d) Regardless of the result of the Test, you agree and understand to follow and comply with all federal, state and local guidelines to reduce the transmission of COVID-19, including, but not limited to, the practice of social distancing, hand washing and sanitization, and the use of masks or face coverings. You agree and understand even with a negative COVID-19 indication, you could still be contagious and will follow all recommendations.

1. **COVID-19 PCR and/or Antigen Test Consent.** You acknowledge, represent, warrant and covenant to MDT the following:

1.1 You understand that COVID-19 PCR Test looks for the COVID-19 virus. You are electing to have this Test to assess whether or not you are currently infected by the COVID-19 virus. This is a more thorough test that provides definitive results with 100% accuracy. Additionally, you understand that if you choose to have this Test outside the timeline guidelines for resolution of symptoms, the results may be less reliable. This Test does not guarantee immunity to COVID-19 or any other virus.

1.2 You understand that COVID-19 Antigen Test looks for the COVID -19 virus. You are electing to have this Test to rapidly assess whether or not you are currently infected by the COVID-19 virus. This test result is considered a preliminary result and will need to be followed up with a COVID-19 PCR test. Additionally, you understand that if you choose to have this Test outside the timeline guidelines for resolution of symptoms, the results may be less reliable. This Test does not guarantee immunity to COVID-19 or any other virus.

1.3 You also understand that the results of these Test/Tests may be given to the applicable local or state health authority or U.S. Centers for Disease Control for their statistical and demographic value.

1.4 Certain infectious diseases and conditions, and the identity of those who test positive for them, are required, by federal and/or state law, to be reported to local or state health authorities by your health care providers, including MDT. The time frames and reporting requirements vary by authority. These local and state health authorities are considered Public Health Authorities under the federal Health Insurance Portability and Accountability Act of 1996 **("HIPAA")** which means they are legally authorized to receive your PHI. However, MDT will not otherwise share or release any PHI, unless mandated by law or authorized by you in writing.

1.5 ***You understand that if your Test returns positive for COVID-19, your Test result and your identifying information will be reported to the applicable local or state health authority. Reporting this information does not require your permission or consent.*** *Additionally, you understand that if your Test returns positive for COVID-19, MDT, will not treat, prescribe medications, or refer you for medical treatment****. It is your sole responsibility to seek and comply with necessary treatment and all required follow-up with your physician or local public health department.***

2. **Waiver. IN FURTHER CONSIDERATION OF BEING TESTED FOR THE PRESENCE OF COVID-19 THE UNDERSIGNED HEREBY AGREES TO THE FOLLOWING: THE UNDERSIGNED, ON HIS OR HER BEHALF HEREBY RELEASES, WAIVES, DISCHARGES AND COVENANTS NOT TO SUE MDT**, its owner(s), employees, volunteers and agents from all liability, claims, actions, damages, costs or expenses of any kind arising out of or relating to COVID-19 testing to the undersigned and all personal representatives, assigns, heirs, and next of kin of the undersigned or such participating children for any loss or damage, and any claim or demands on account of any injury to, or an illness or the death of, the undersigned (or any person who may contract COVID-19, directly or indirectly, from the undersigned) whether caused by actions, omissions, or negligence of MDT or otherwise while the undersigned undergoes COVID-19 testing, this includes testing accuracy and reliability in testing included but not limited to false positive or false negative or otherwise inaccurate, un-interpreted, misinterpreted or results not received. **THE UNDERSIGNED HEREBY ASSUMES FULL RESPONSIBILITY FOR, AND RISK OF ILLNESS, BODILY INJURY, OR DEATH** in connection with accuracy and reliability in testing included but not limited to false positive or false negative or otherwise inaccurate, un-interpreted, misinterpreted or results not received. **YOU ARE AW ARE THAT BY SIGNING THIS AGREEMENT YOU ARE GIVING UP VALUABLE LEGAL RIGHTS, INCLUDING THE RIGHT TO RECOVER DAMAGES FROM MDT IN CASE OF ILLNESS, INJURY and/or DEATH. YOU UNDERSTAND THAT THIS DOCUMENT IS A PROMISE NOT TO SUE AND A RELEASE OF AND INDEMNIFICATION FOR ALL CLAIMS.**

3. Governing Law; Severability. This Consent shall be governed and construed in accordance with the laws of the State of Texas. If a provision of this Consent or any provision hereafter adopted shall for any reason be found to be inapplicable, invalid, illegal or unenforceable in any respect, such inapplicability, invalidity, illegality or unenforceability shall not affect the other provisions of this Consent, but the Consent shall be construed as if such provision had never been contained herein, or in the alternative, such provision shall be modified to the extent of such inapplicability, invalidity, illegality or other unenforceability.

4. Arbitration. Any dispute, claim or controversy arising out of or relating to this Consent or the breach, termination, enforcement, interpretation or validity thereof, including the determination of the scope or applicability of this agreement to arbitrate, shall be determined by arbitration in San Antonio, Texas before a single arbitrator agreed to by the parties. The arbitration shall be administered by the American Arbitration Association. Judgment on the arbitration award may be entered in any court having jurisdiction. This clause shall not preclude parties from seeking provisional remedies in aid of arbitration from a court of appropriate jurisdiction.

5. Result Delivery. MDT will notify you when results are available via email, text and or phone call from the information provided on the Testing Information Form.

Client Name: ________________________ Date: _______________

Signature: ___________________________ Client or Guardian

Printed Name:________________________ (Please Circle One)