VHS HEARING SOLUTIONS
Better Hearing Starts Today

NSAF MEET TO CHAMPIONS MYRTLE BEACH, SC 2021

COVID 19 ANTIGEN TESTING PROCEDURES

Thank you for working with VHS for your COVID testing!
Please follow the instructions below prior to your testing.

FOR YOUR FIRST TESTING DATE:

- ☐ Bring your Photo ID Card
- ☐ Bring your medical ID Card
- ☐ Fill out complete Superbill Form - *Must be signed by parent if under 18*
- ☐ If under 18 years old, have parent consent waiver signed

FOR EACH TESTING DATE AFTER THE FIRST:

- ☐ Fill out Superbill Form - **Only need Name, Date of Birth & Address**

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COVID EVENT SUPERBILL

DATE:_____

PATIENT INFORMATION

NAME:_____ DATE OF BIRTH:_____ GENDER:_____

PHONE:_____ EMAIL:_____

ADDRESS:_____

PREFERRED LANGUAGE:_____

INSURANCE PROVIDER:_____ MEDICAL #:_____

MEDICAL RELEASE- THE PATIENT ABOVE AGREES THAT VIRTUAL HEARING SOLUTIONS MAY SHARE RESULTS TO EVENT ORGANIZERS FROM _____

PATIENT SIGNATURE:_____

UNDER 18 YEARS OLD PARENT CONSENT :

I UNDERSTAND I NEED TO SIGN THIS BEFORE MY CHILD CAN BE TESTED.

I,_____, GIVE CONSENT TO VHS AND ITS EMPLOYEES AND/OR CONTRACTORS TO EXAMINE AND TEST MY CHILD _____

PARENT/GUARDIAN SIGNATURE: _____

MEDICAL STAFF USE ONLY

TESTED BY:_____

RAPID TEST RESULTS:

ANTIGEN: P___ N___ ANTIBODY: P___ N___

COVID CODES:

____U0001-CDC 2019-nCoV Real-Time RT-PCR Diagnostic Panel

____86328- Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single step method (eg, reagent strip); severe acute respiratory syndrome coronavirus 2(SARS-CoV-2) (Coronavirus disease [COVID-19])

____G2023-COVID19 Specimen Collection (Any Source).

____ 1) Super Bill Antibodies Test/ Specimen (U0001, U0004, 86328, G2023,

____ 2) Super Bill Swab Test/Specimen (U0001, U0002, U0003, G2023

____ 3) Super Bill Swab/Antibodies Test/ Specimen (U0001, U0002, U0004, 86769, G2023)

____ 4) Super Bill Antigen Testing (99072,87811,87428)

____ 5) Superbill Rapid Retest /Specimen (U0001, 86328, G2023)

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Parent Consent Form/Medical Release Form

I understand that Virtual Hearing Solutions (VHS) requires a signed consent for Covid-19 testing. I understand I need to sign it before my child can be tested. I,_____, give consent to VHS and its employees and/or contractors to examine and test my child _____ and/or myself by signing this form. I understand that: I can cancel this Consent in writing. If I notify VHS in writing to cancel this Consent, VHS may no longer examine and treat the patient; and that there are no guarantees for outcomes and results. VHS will be responsible for all specimen handling and the performance of all testing.

SPECIMENS AND BLOOD TESTING I understand that a health care provider may accidentally come into contact with the patient's body fluids. If this happens, I consent to testing the patient for infectious diseases. I agree that the exposed person may be given the results. I understand that the law may require VHS to report some medical outcomes to the government.

PARENT CONTACT INFORMATION AND USE OF HEALTH INFORMATION I agree to tell VHS how to reach me such as by phone, cell phone, fax, mail, or e-mail. By providing VHS with my cell phone and/or landline phone, I agree to be contacted via text message, voice and/or recorded call by VHS or its contracted business associates for all healthcare calls to include: appointment reminders, pre-registration instructions, prescription notifications, accounting, billing, or debt collection. I understand that VHS follows all federal and local laws including the Health Insurance Portability and Accountability Act. I understand that this Consent allows VHS to use private health information for treatment, payment and hospital operations as defined in the Notice of Privacy Practices. I agree that VHS may use de-identified health information about the patient for approved research and quality improvement activities.

PAYMENT, INSURANCE, AND ASSIGNMENT OF BENEFITS AUTHORIZATION I assign to VHS the right to bill and collect from any insurance that covers the patient. I agree to help VHS seek payment and to tell VHS about any resources for payment of the patient's bill.

PATIENT IDENTITY My signature below means that I have given truthful information about the patient's name and identity. It also means that I understand: How important it is to provide truthful and accurate information about the patient's name and identity. That incorrect or false information about identity can lead to treatment that could be harmful to the patient. That VHS reserves the right to take action for intentional presentation of false information including transfer of care and appropriate reporting to authorities.

MEDICAL RELEASE:

I authorize the release of medical information pertaining to my Covid-19 examinations and results rendered to me and claims information. This information may be released to _____.

Patient Name: _____

Signature of Parent/Legal Guardian _____

Date/Time: _____

Relationship to Patient_____ Phone Number _____