Hummingbird
COVID Testing Centers By DHS

COVID-19 Test Agreement

IF ANY INFORMATION IS FALSE, YOU WILL BE BILLED FOR THE OUT-OF-POCKET COST.
MEDICARE/ MEDICAID NOT ACCEPTED

PATIENT CONSENT: Your signature below and participation is an acknowledgment that you agree with and confirm the following:

1. I authorize Hummingbird Covid Testing Centers (Hummingbird) and its employees to conduct collection and/or testing for COVID-19 through a nasopharyngeal swab to detect active infection.

2. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law, and my employer and/or the company for whom I'm performing work or providing services in the case I test positive for active infection.

3. I acknowledge that a positive test result is an indication that I must continue to self-isolate in an effort to avoid infecting others.

4. I understand that Hummingbird is not acting as my medical provider, this does not replace treatment by my medical provider, and I assume complete and full responsibility to take appropriate action with regards to my test results, and that Antigen and PCR tests can only detect the presence of the virus at a particular moment in time, and cannot replace other safeguards for the protection of others.

5. I understand that, as with any medical test, there is the potential for false positive or false negative test results can occur and that I have the right to discuss the proposed testing with a physician to learn about the purpose, potential risks and benefits of any testing. I also understand that I can opt to receive a PCR test only or a Rapid Test only. I also understand that I may request both tests. My initials below serve as my consent to receive both tests.

6. I understand that my insurance will process each claim based on their contractual agreement with the testing site and will reimburse within the allowed amounts set forth. *If my claim is processed out of the network, there is a potential that the payment for services rendered may be sent directly to me. In this case, it is my responsibility to forward this payment to the address of my testing site*. I understand that the billing service will not charge me for these *COVID-19* test(s) but will hold me responsible for contacting the site, if payment is issued to me by the insurance company.

By signing below, you also agree to release and waive any claim that might arise against Company and its designated medical provider, Hummingbird and staff members for any risks, side effects, or complications resulting from the testing.

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this Informed consent. I have been given the opportunity to ask questions before I sign, and am informed of my right to ask further questions at any time regarding testing

ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize payment to Discovery Health Services/Hummingbird. I represent that I have insurance coverage and do hereby authorize Discovery Health Services/Hummingbird to release and obtain all information necessary to secure payment of said benefits. If my insurance fails to pay Discovery Health Services/Hummingbird for any reason, I agree to pay all unpaid balances.

I HAVE READ AND UNDERSTAND MEDICAL PRODUCT DISCLOSURE, MEDICARE ASSIGNMENT, AND ASSIGNMENT OF INSURANCE BENEFITS AND AGREE TO ALL TERMS STATE