INFORMED CONSENT FOR COVID-19 TESTING

Office Use ONLY:

RefBy:

1. Please complete the following information:

Patient Name_________________________Date of Birth______________Age______

Patient Address____Zip______________

County of Residence_______________ Patient Phone Number________________________________

Email____.

Patient Ethnicity: White Hispanic/Latino Black/African American Asian American Indian/Alaskan Native

Native Hawaiian/Other Pacific Islander.

Have you traveled anywhere outside of Nevada in the past 1 month?

YES *(where)*_______________________________________ NO. Not Applicable

2. Have you been in close contact (i.e. within 6 feet) with someone confirmed to have COVID-19? NO YES UNKNOWN

1. Authorization and Consent for Covid-19 Testing:

I, (**name**)____ voluntarily consent and authorize ***Dr. Silva Battaglin & Dr. Adam Persky of TOBP LLC ("TOBP LLC") of*, *10161 Park Run Drive #150, Las Vegas, NV 81945*** to conduct collection, testing, and analysis for the purposes of a COVID-19 diagnostic test. I acknowledge and understand that my COVID-19 testing will require the collection of an appropriate sample by my dental care provider through a single drop of blood, or other recommended collection procedures. I understand that there are risks and benefits associated with undergoing testing for COVID-19 and there may be a potential for false positive or false negative test results. I assume complete and full responsibility to take appropriate action with regards to my test results. Should I have question or concerns regarding my results, or a worsening of my condition, I shall promptly seek advice and treatment from an appropriate medical provider. Every attempt will be made to get reimbursed, but for some reason my medical insurance does not cover this test, I agree to pay a fee of $75 to TOBP LLC within 30 days of getting notified.

2. Patient Rights and Privacy Practices

a) Notice of Privacy Practices and Patient Rights: TOBP LLC Notice of Privacy Practices describes how it may use and disclose your protected health information to carry out treatment, initiate and obtain payment, conduct health care operations and for other purposes that are permitted or required by law. I acknowledge that TOBP LLC has provided me with a copy of TOBP LLC Notice of Privacy Practices.

b) Disclosure to Government Authorities: I acknowledge and agree that TOBP LLC may disclose my test results and associated information to appropriate county, state, or other governmental and regulatory entities as may be permitted by law.

3. Release

To the fullest extent permitted by law, I hereby release, discharge and hold harmless, TOBP LLC, including, without limitation, any it's respective, doctors, medical professionals, officers, directors, employees, representatives and agents from any and all claims, liability, and damages, of whatever kind or nature, arising out of or in connection with any act or omission relating to my COVID-19 diagnostic test or the disclosure of my COVID-19 test results.

By signing below, I acknowledge and agree that I have read, understand, and agreed to the statements contained within this form. I acknowledge that I have a basic command of the English language. I have been informed about the purpose of the COVID-19 diagnostic test, procedures to be performed, potential risks and benefits, and associated costs. I have been provided an opportunity to ask questions before proceeding with a COVID-19 test and I understand that if I do not wish to continue with the collection, testing, or analysis of a COVID-19 diagnostic test, I may decline to receive continued services. I have read the contents of this form in its entirety and voluntarily consent to undergo testing for COVID-19.

_______________________________________ _______________________

Signature of patient/guardian **Date**

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TEST RESULTS		
NEG.	**POSTIVE/NOT CONTAGIOUS.**	**CONTAGIOUS**