Center of Advanced Wellness

BE PREPARED TO/ ESTE LISTO PARA

Present VALID (government Issued) ID & Insurance card.

Presentar Identificacion valida y tarjeta de seguro medico

NG
NA
RA
AN

Is this your first time here?_____Primera vez aqui?_____

Name/Nombre:	SSN	DOB /Fecha de Nacimiento
Email:		
Address/Domicilio:		Apt#
City/Ciudad:	State/Estado:	Zip/Codigo postal
Mobile Phone/Telefono:	Circle one/Circule uno Male/ Hombre or/o Female/Mujer:	

Ethinicity Circle one/ Origen Etnico Circule uno	
Asian	Asiatico
Black or African American	Negro o Afroamericano
Hispanic or Latino	Hispano o Latino
Native Hawaiian or Pacific Islander	Nativo Hawaiano o de Las Islas de Pacifico
White	Blanco
Unknown	Origen desconocida

Insurance Information/ Informacion de Aseguranza Medico

Your Test will be billed to your Insurance Company. YOU MUST provide your insurance card (if you have Insurance) and a VALID photo Identification. NO EXCEPTIONS We will make copies for our Records.
Su Prueba va a ser cobrada a su aseguranza medica.
Tiene que presentar su tarjeta de aseguranza (si la tiene) y Identificacion con foto valida.
NO EXCEPCIONES. Nosotros haremos copias.
Attach copy / Sujetar copia

Runner:_____ Varifier:_____

"I state under penalty of perjury under the laws of the United States of America that the foregoing is true and correct.

_____I HAVE Health Insurance/Tengo Seguro Medico (must be provided or test will not be administered)

(Tiene que presentar su tarjeta de suguro, o su prueba no sera administrada)

_____I DO NOT have Health Insurance/ No Tengo Seguro Medico

X_____Date:_____

Patient Consent for Covid-19 Testing

I _____ (patient's name) hereby consent to the Covid-19 testing IGG/IGM antibody testing and/or Nasopharyngeal swab to be performed by Center of Advanced Wellness. With either testing, it is understood that no test is 100% accurate. By signing below, I agree to have the Covid-19 test performed and understand that there is no Refunds.

_____ X _____

Patient's Name (Print) Patient's Signature

_____ _____

Date Legal Guardian or authority if not signed by patient.

HIPAA Privacy Practices

When is HIPAA Authorization Required? 45 CFR §164.508 details the uses and disclosures of PHI that require an authorization to be obtained from a patient/plan member before information can be shared or used. HIPAA authorization is required for: Use or disclosure of PHI otherwise not permitted by the HIPAA Privacy Rule.

Please read the following information carefully:

1) I understand and acknowledge that I am consenting to the use and/or disclosure of personally identifiable health information about me by The Center of Advanced Wellness for purposes of testing me, obtaining payment for testing, and as necessary in order to carry out any healthcare operations that are permitted in the regulation.

2) I am aware that the practice maintains a Privacy Notice which sets forth the types of uses and disclosures that practice is permitted to make under the Privacy Regulations and sets forth in detail the way in which the practice will make such use or disclosure. By signing this consent, I understand and acknowledge that I have the right to review the Privacy Notice prior to signing this consent form.

3) I understand and acknowledge that I have the right to request that the Practice restricts how my information is used or disclosed to carry out testing, payment, treatment, or healthcare operations. I understand and acknowledge that the practice is not required to agree to restrictions requested by me, but if the practice agrees to such a requested restriction it will be bound by that restriction until I notify it otherwise in writing. I request the following restrictions be placed on the practice's use and/or disclosure of my health information (Leave blank if no restrictions):

_____

4) I understand and acknowledge that I may revoke this consent at any time by sending a written revocation to the practice at the address set forth in (3) above. However, I also understand and acknowledge that if I revoke this consent, my revocation will not be effective to the extent that the practice has already acted action in reliance on this consent.

_____ X _____

Patient's name Patient's Signature (or Legal Guardian)

Advanced Wellness

Questionnaire/ Cuestionario

Name:_____ DOB/Fecha de Nacimineto:_____

Date of Service/ Fecha de visita:_____ Temperature/Temperatura:_____

1.Do you have a fever (temperature over 100.3F) without having taken any fever reducing medication? Tiene fiebre (temperatura mas de 37.8 C) sin haber tomado medicamento para reducir su temperatura.

Ö YES / SI Ö NO

2.Loss of Smell or taste? Perdida de olor o sabor? Ö Yes / SI Ö NO

Muscle Aches? Dolor de musculos? Ö Yes / SI Ö NO

3. Sore throat? Dolor de garganta? Ö Yes / SI Ö NO

Cough? Tos? Ö Yes / SI Ö NO

4. Shortness of Breath? Le falta el aire? Ö Yes / SI Ö NO

Chills? Escalofrio? Ö Yes / SI Ö NO

Headache? Dolor de cabeza? Ö Yes / Si Ö NO

5. Have you experienced any gastrointestinal symptoms such as nausea/ vomiting, diarrhea, loss of appetite? Ha tenido nausea, vomito, diarrea, o perdido de apetito?

Ö Yes / SI Ö NO

6. Have you, or anyone you have been in close contact with been diagnosed with Covid-19, or been placed on quarantine for possible contact with COVID-19? ha usted sido diagnosticado con, o ha estado en contacto con alguna persona con COVID-19, o ha sido puesto en cuarentena por posible contacto con una persona infectada.

Ö Yes / SI Ö NO

6. Have you been asked to self-isolate or quarantine by medical professional or local public health official? Algun profesional medico o funcionario de salud publica le ha pedido asilarse por si mismo o que se ponga en cuarentena?

Ö Yes / SI Ö NO

Please email results to patient:_____

Skippack Medical Lab

200 Rittenhouse Circle East Suite 9
Bristol, PA 19007
Laboratory Director: G. Vahora, MD, PhD
CLIA: #39D0721755
Tel: (610)-584-1669
Fax: (267)-812-5218

Ordering Physician/Employer Dr. Michael Gomez DNP, FNP-C
Information: Practice Name/Employer: Center Of Advanced Wellness
Address: 8723 Botts Lane
San Antonio TX 78217
210-922-4455

INFECTIOUS DISEASES REQUISITION

A PATIENT INFORMATION — REQUIRED

Last Name:_____ Middle Name:_____ First Name:_____ Gender: ☐M ☐F

Date of Birth: __/__/____ SSN:_____ *ATTACH A COPY OF THE PATIENT DEMOGRAPHICS AND INSURANCE INFORMATION*

B PATIENT BILLING/PAYMENT INFORMATION — REQUIRED

Insurance ID *ATTACH COPY OF FRONT AND BACK OF ID*

Relationship with Policy Holder:_____
Policy Holder Info:_____
DOB:_____ ☐ Self-Pay ☐ Client Bill ☐ Insurance

C PATIENT CONTACT INFORMATION — REQUIRED

Patient Address:_____

Patient Phone Number:_____

D TEST ORDER — REQUIRED

☐ SARS-CoV-2 RTPCR (Covid-19)
☐ SARS-CoV-2 Antibody (Covid-19)
☐ Respiratory Pathogen Panel (includes the following organisms)

Viruses

☐ SARS-CoV-2 RTPCR (Covid-19)
☐ Coronavirus -- 229E
☐ Coronavirus -- NL63
☐ Coronavirus -- OC43
☐ Coronavirus -- HKU1
☐ Adenovirus
☐ Enterovirus
☐ Parainfluenza (Type 1)
☐ Parainfluenza (Type 2)
☐ Parainfluenza (Type 3)
☐ Parainfluenza (Type 4)
☐ Human Metapneumoviruses A/B
☐ Respiratory Syncytial Virus (RSV) A/B
☐ Influenza A
☐ Influenza B
☐ Influenza C
☐ Influenza A (H1N1)
☐ Human Bocavirus
☐ Human Parechovirus
☐ Human Rhinovirus

Fungus

☐ Pneumocystis jirovecii

Bacteria

☐ Bordetella spp
☐ Chlamydophila Pneumoniae
☐ Haemophilus Influenzae
☐ Haemophilus Influenzae B
☐ Klebsiella Pneumoniae Legionella
☐ Neumophila Moraxella
☐ Catarrhalis
☐ Mycoplasma Pneumoniae
☐ Staphylococcus Aureus
☐ Streptococcus Pnumoniae
☐ Salmonella spp

Ethnicity/Race *(Check all that apply)*

☐ African American
☐ Ashkenazi Jewish
☐ Asian
☐ Caucasian
☐ Hispanic
☐ Middle Eastern
☐ Native American
☐ Pacific Islander
☐ Other

E DIAGNOSIS (ICD-10) CODES — REQUIRED

Respiratory Codes

The ICD-10 codes provided are based on AMA guidelines and are for information purposes only. ICD-10 coding is the sole responsibility of the ordering provider.

( ) **Z20.828** Contact/suspected exposure to viral communicable diseases
( ) R50.9 Fever, Unspecified
( ) R.06.02 Shortness of Breath
( ) R06.00 Dyspnea, Unspecified
( ) J02.9 Acute Pharyngitis
( ) J01.90 Acute Sinusitus, Unspecified
( ) J00 Acute Nasopharyngitis
( ) J32.9 Unspecified Sinusitus, Chronic
( ) R09.3 Abnormal Sputum
( ) J44.9 Asthma with chronic obstructive pulmonary disease (COPD) (HCC)
( ) J03.90 Acute Tonsillitis
( ) R07.81 Pleurodynia
( ) R53.82 Chronic Fatigue, Unspecified
( ) J31.0 Unspecified Rhinitis
( ) R05 Cough
( ) R68.83 Chills (without fever)
( ) R06.9 Abnl breathing, Unspecified
( ) R07.82 Intercostal chest pain
( ) J40 Bronchitis, Unspecified
( ) J43.2Emphysema, Centrilobular
( ) R06.01 Wheezing
( ) J43.9 Emphysema, Unspecified
( ) J06.9 Acute Upper Respiratory Infections of Unspecified Site
( ) R91.1 Pulmonary Nodule, Solitary

F SPECIMEN INFORMATION

☐ Nasopharynx Swab ☐ Blood

Collector's Name:_____ Collection Time: _____ AM PM

Additional ICD-10 Codes

PATIENT ACKNOWLEDGMENT

I certify that I have voluntarily provided a fresh and unadulterated specimen for analytical testing. The information provided on this form and on the label affixed to the specimen is accurate. I hereby authorize Skippack Medical Lab, LLC (SML) or its assignee to bill any and all insurance/health coverage on my behalf for laboratory services rendered by a performing CLIA Laboratory. I irrevocably assign to and direct that payment be made to SML. I also authorize SML to release any information required for billing and reimbursement. I further authorize a performing CLIA Laboratory to release the results of this testing to the treating authorized healthcare provider or facility. I acknowledge that SML may be out-of-network facility/provider with my insurance provider. I am also aware that in some circumstances my insurance provider may send payment directly to me. I agree to endorse the insurance check and forward it to SML within 15 days of receipt as payment towards the lab services provided by a performing CLIA Laboratory. I acknowledge that I am responsible for any amounts not covered by my insurer including any deductibles and co-payments co-insurance. I understand that a performing CLIA Laboratory may use my specimen and any testing performed on that specimen for research and development so long as the information has been identified pursuant to law.

G AUTHORIZED HEALTHCARE PROVIDER ACKNOWLEDGMENT — REQUIRED

I acknowledge that documentation to support medical necessity for all tests ordered is recorded in the patient's chart. If not signed, Authorized Healthcare Provider affirms that test orders are placed in patient file with provider signature and will be available upon request. The Office of the Inspector General requires documentation in patient medical chart including date of service, tests ordered and documentation to support medical necessity.

Provider Name:_____ **Signature:**_____ **Date:**_____

H PATIENT ACKNOWLEDGMENT — REQUIRED

This specimen was provided voluntarily for analysis and I authorize SML or its assignee to process, bill and administer results per the policy outlined on the back of this form.

Patient Signature:_____ **Date:**_____

Date Stamp

Lab Use Only