

**ORDER REQUISITION FORM**

Date of service: \_\_\_\_\_

**PATIENT NAME & ADDRESS**

First name: \_\_\_\_\_ Last name: \_\_\_\_\_

DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Phone number: \_\_\_\_\_

please write very clearly to ensure we communicate with the correct person

**ORDERING PROVIDER**

**REQUESTED STUDIES**

Electronically signed by:

Dr. Lauren Davis, DO

Dr. Chris Davis, DO



COVID19 Rapid Antigen Test

For internal use:

Results:  positive  negative

**Disclaimer:**

By signing below, I acknowledge that I desire to have the COVID19 rapid antigen test as acknowledged by the FDA Emergency Use Act.

I acknowledge that if I test too early following a known exposure (before 3-5 days from my last known exposure) and my test is negative, it may be a false negative. I agree to seek medical care if my symptoms are concerning. If I test positive, I agree to quarantine myself per the CDC guidelines.

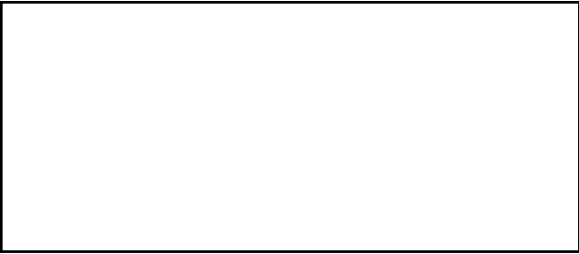
I acknowledge that Dr. Lauren and Dr. Chris Davis are available via telemedicine if you have further questions or desire molecular PCR testing.

Lastly, at the time of this signed form, there is no associated diagnosis code for this procedure/service and therefore cannot be correctly processed or paid by Medicare or commercial insurances because they do not have the pertinent or required information. Insurances require a CPT code (known) AND a diagnosis code (ICD10, unknown).

Your signature below acknowledges that you have read the above disclaimer and agree that your insurance cannot be billed for this optional service and that you are responsible for paying the \$125 associated with the administration and reading of this optional COVID19 rapid test.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



*This form is not valid without a stamp*