Lehigh Valley Genomics – Consent Form

Full Name:	Today's Date:
Date of Birth: (MM/DD/YYYY)	Gender:
Home Address:	
Telephone:	
Insurance Plan Name:	
Insurance Member ID:	
Ordering Provider:	
Ordering Provider Office:	
Ordering Provider Phone:	

Do you currently have any symptoms of COVID-19? Yes ☐ No ☐

If yes, when did your symptoms begin? _____ / _____ / _____

Sequencing Authorization & Consent:

If your test is **positive**, LVG can sequence your COVID-19 sample to determine your variant.

For tests using Insurance: LVG will bill for this service through insurance.

For Self-Pay tests: this is an additional $150 charge per sample.

If my test is positive, aka "Detected" for COVID-19, I consent to LVG billing me the additional charges listed above.

☐ I **accept** the terms if my sample is positive.

☐ I **decline** the terms if my sample is positive.

Consent:

The specimen identified on this form is my own. I have not adulterated the specimen in any way. I am voluntarily submitting this specimen for analysis by Lehigh Valley Genomics. I authorize the lab to release the results of this test to applicable departments of health and my primary care provider. Lehigh Valley Genomics is authorized to bill me to receive payment of benefits for this test and I agree to reimburse Lehigh Valley Genomics for any portion of the test not paid for by an insurance company or other means.

Patient Signature: _____ Date _____

Guardian Signature (if under 18 years of age): _____ Date _____