YZ HEALTHCARE P.A

1651 Justin Rd

Flower Mound, Tx 75028

P: 972-691-9800 F: 940-205-4454

yzhealthcare@gmail.com

Patient Name: _____

Date of Birth:_____

Insurance Name (if applicable):_____

Insurance Member Id Number (If applicable):_____

Driver License Number:_____

Legal Guardian/Parents Name(FOR MINOR): _____

Legal Guardian/Parents DOB (FOR MINOR)_____

SSN:_____

Phone Number:_____

Email Address:_____

I am consenting to be tested for Covid-19/flu. The following has been explained to me, and I agree:

_____ I have consented to today's and **all future** Covid tests/flu tests done for me at YZ Healthcare.

_____ A positive test is considered diagnostic, and no confirmatory testing will be performed.

_____ By law, the Texas Department of State Health Services (DSHS) will be notified that I was tested, and what the test results are.

_____ In addition, if I test positive I agree to comply with instructions given to me by the staff.

IF Patient is under age of 18 please send us Legal Guardians/Parents photo ID

Printed name: _____ Signature_____

Date:_____

Please take a picture of completed consent and email it back to yzhealthcare@gmail.com

We cannot release results until we get this form back!