URGENT CARE
american family care

Covid-19 Rapid Testing Instructions

Please do not come into the clinic

1. Park your car near the front door of our clinic and take form from registration box on clinic window.
2. Please fill out registration form, Covid questionnaire and email completed forms, along with your photo ID and insurance card to **kentteam@afcurgentcare.com** if you do not have insurance, telemedicine visit and Covid test is $250. Payment will be collected over the phone.
3. Once you have emailed the completed forms please call **425.291.3300,** inform front desk staff that you are here for the Covid-19 test and that you have emailed the completed forms.
4. Medical Assistant will come out to your car and provide instructions to perform nasal self-swab, this will be completed in your car.
5. Once the swab has been completed you can leave and you will receive a text message and invite to a Zoom meeting for a telemedicine visit with our provider.
6. Medical provider will inform you of your test result and discuss any discharge instructions via Zoom.
7. Once your telemedicine visit is completed, your results and discharge summary will be emailed to you in a secure email.

18012 West Valley Highway Suite 101
Kent, WA. 98032
Phone: 425-291-3300
Email: kentteam@afcurgentcare.com

Parking Cone #

Patient Registration Form

EMAIL COMPLETED FORMS, INSURANCE CARD & PHOTO II

kentteam@afcurgentcare.com

What's the reason for your visit today? COVID-19 TEST

PATIENT INFORMATION

Name: ☐ Male ☐ Female

Date of Birth: SS#:

Mailing Address: Apt#:

City: State: Zip:

Home Ph#:

Cell Ph#:

Home Email:

Primary Care Physician (PCP):

PCP Address:

PCP Ph#:

Preferred Pharmacy:

Pharmacy Ph#:

*Confidential Phone:

*Confidential Email:

*For more information on the confidential phone and email, please see the attached consent form.

EMERGENCY CONTACT INFORMATION

Name:

Relationship:

Home Ph#:

Cell Ph#:

Based on government regulations, we are required to ask the following:

What is your preferred language:

Race: ☐ I prefer not to answer

Ethnicity: ☐ I prefer not to answer

Best Form of Contact: ☐ Cell ☐ Home ☐ Email ☐ Mail

Best Time to Call: May we leave a message? ☐ Yes ☐ Nc

INSURANCE INFORMATION

Primary Ins: Ins #:

Name of Insured:

Date of Birth:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Secondary Ins: Ins #:

Name of Insured:

Date of Birth:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFITS

☐ Check if same as patient information. If not, please complete the entire section.

Name: ☐ Male ☐ Female

Date of Birth: SS#:

Relationship:

Phone #:

I acknowledge full financial responsibility for any services rendered and I understand that the payment of charges incurred in this office are due at the time of service. I also understand that the charges not covered by insurance remain my responsibility and assign insurance benefits to this office. In the event my account is turned over to a collection agency, I agree to pay all costs of collection fees and/or attorney's fees and all court costs if any. I agree to be contacted at any telephone number or email address associated with my account. This includes cellular telephone numbers or other wireless devices. I understand this could result in a charge from my phone or device carrier to me for talk time, SMS messaging/texts or data usage for emails or voice mails. I also understand methods of contact may include pre-recorded /artificial voice messages and/or the use of automatic dialing devices as applicable.

Signature

Date

CONSENT FOR TREATMENT

I, the undersigned, consent to the care and treatment by the attending Physician, his/her associates or assistants and acknowledge that no guarantees have been made as to the effect of such treatment.

Signature Date

NOTICE OF PRIVACY PRACTICES

I have reviewed the Notice of Privacy Practices as provided at registration and understand that I may request a copy of the policy at any time.

Signature Date

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Name: _____

Date of Birth: _____

Please answer all questions to the best of your ability

Why are you testing for Covid-19 today? Circle One: Travel Direct Contact Symptoms

Travel: Where are you traveling to: _____ Traveling from? _____

Direct Contact: When: _____

With whom: _____ (i.e. Co-worker, family member, friend etc)

Do you live in the same household?	Yes	No
1. Do you have a fever or have you felt feverish?	Yes	No
2. Do you have a cough?	Yes	No
3. Are you having shortness of breath?	Yes	No
4. Do you have any body aches?	Yes	No
5. Have you had any headaches?	Yes	No
6. Have you had a sore throat?	Yes	No
7. Are you experiencing any nausea?	Yes	No
8. Are you experiencing fatigue?	Yes	No
9. Any recent diarrhea?	Yes	No
10. Any recent vomiting?	Yes	No
11. Have you had recent loss of smell?	Yes	No
12. Have you had recent loss of taste?	Yes	No
13. Have you been diagnosed with Covid-19 prior?	Yes	No
14. Do you have history of diabetes?	Yes	No
15. Do you have history of kidney disease?	Yes	No
16. Do you have history of COPD or any chronic lung disease?	Yes	No
17. Do you have history of cardiac disease? (i.e. prior heart attacks, hypertension?	Yes	No
What is your height? _____		
What is your weight? _____		
Are you over 65 years old?	Yes	No
Are you over 55 years old?	Yes	No
Have you received a flu vaccine this season?	Yes	No

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