

**LEXINGTON PRESCRIPTION CENTER**

Pharmacy NPI: 1750465357

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Specimen ID: (for lab use)

**PATIENT INFORMATION**  Rapid Covid AG Test  Rapid Covid PCR Test  Covid Antibody Test

NAME: Last		First	M.I.	Home Phone:	
Date of Birth:	Sex: M F	Email address		Cell Phone:	
ADDRESS: Street		City	County	State	Zip Code
Race: Please check one <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black / African American <input type="checkbox"/> Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____		Ethnicity: Please check one <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Unknown <input type="checkbox"/> Other: _____		Please circle the correct answer (Y=yes N=No U=Unknown) 1. Is this your first Covid test of any kind? Y N U If NO, have you ever tested POSITIVE for Covid? Y N U If so, when? _____ 2. Are you employed in Healthcare? Y N U 3. Were you a resident in a congregate care setting (nursing home, residential care for people with intellectual and developmental disabilities, psychiatric treatment facilities, group homes, board and care homes, homeless shelter, foster care or other setting? Y N U 4. Are you pregnant? Y N U 5. Have you had all, or part of a Covid vaccination? Y N U	
When do you think you were exposed to Covid -19? (testing should take place 5-7 days after exposure for best results)			Date of exposure: _____		
Are you currently experiencing symptoms? Y N (symptoms may occur 2-14 days after exposure to the virus)			Have you had symptoms within the past 14 days? Y N Date of symptom onset: _____		
Symptoms - check all that apply: (testing should take place within the first 5 days after symptoms start for best results)					
<input type="checkbox"/> Fever or chills	<input type="checkbox"/> Cough	<input type="checkbox"/> Shortness of breath or difficulty breathing	<input type="checkbox"/> Fatigue		
<input type="checkbox"/> Muscle or body aches	<input type="checkbox"/> Headaches	<input type="checkbox"/> New loss of taste or smell	<input type="checkbox"/> Sore throat		
<input type="checkbox"/> Congestion or runny nose	<input type="checkbox"/> Nausea or vomiting	<input type="checkbox"/> Diarrhea			

**PHYSICIAN INFORMATION (Optional)**

Practice Name:	Practitioner:	Phone #:
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**CONSENT AND RELEASE** To agree to participate in this test, please initial boxes, sign, print name and date this form. Thank you.

- I have read, and I understand the "Fact Sheet for Patients" provided to me.
- In consideration of my participation in this test, I hereby agree to assume all risks. I also understand that results are not designed to replace the care or advice of a medical provider. I understand that if I receive abnormal laboratory test results, I should promptly consult with a physician.
- This test will not be billed to insurance by Lexington Prescription Center. You will receive a receipt and invoice after testing to submit to insurance if you chose. Coverage is not guaranteed. Your insurance may reimburse the full amount, a portion of the amount, or not at all.

Signature of Participant  
(or parent or legal guardian if patient is under 18 years of age)Printed name of participant  
(or parent or legal guardian if patient is under 18 years of age)

Date

For Lab use only:

**SPECIMEN COLLECTION INFORMATION**

Collection Date	Time	Initials	SPECIMEN SOURCE: Swab of Internal Nose	Remarks:
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**SARS-CoV2 TEST RESULTS**

<input type="checkbox"/> BD Veritor System for Rapid Detection of SARS-CoV2 Antigen in Respiratory System	<input type="checkbox"/> Mesa Biotech Accula System for detection of SARS-CoV-2 N gene in nose by NAA with probe detection
Testing date:	Tested by:
<input type="checkbox"/> Presumptive negative test for SARS-CoV-2 (no antigen detected)	<input type="checkbox"/> Negative test for SARS-CoV-2 (not detected)
<input type="checkbox"/> Positive test for SARS-CoV-2 (antigen detected)	<input type="checkbox"/> Positive test for SARS-CoV-2 (detected)



## **COVID TESTING AND PAYMENT INFORMATION**

***Please arrive on time. If you are going to fill out paperwork at the Pharmacy, please arrive a few minutes early. Please park in front of the Pharmacy, next to the small, green shed for testing. After filling out your information, please remain in your car and call the Pharmacy at 463-9166 to let us know you are ready. Someone will be with you shortly to begin your test.***  
**Participants and passengers are required to wear masks.**

### **Testing Prices**

Rapid Covid Antigen Test:	\$129.00 (Results are ready in ~20 minutes after collection)
Rapid Covid PCR Test:	\$169.00 (Results are ready in ~30-40 minutes after collection)
Covid Vibrant Antibody Test	\$169.00 (Results are back in ~3-4 days after collection)
Covid Vibrant PCR Test	\$199.00 (Results are back in ~ 2-3 days after collection)

Payment for testing is due before testing will be performed. This test is NOT billed to insurance by Lexington Prescription Center. You will receive a receipt and an invoice after testing is complete to submit to insurance is you choose. Coverage is not guaranteed. Your insurance may reimburse the full amount, a portion of the amount, or not at all. Insurance may not reimburse if testing is for travel purposes. It is best if you call your insurance company prior to testing if you have questions regarding reimbursement.

### **Payment Information**

We accept cash, checks, or credit cards. If you are paying by credit card, you may give your card to the person performing the testing **OR** you may fill out the credit card information below.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name on Credit Card: \_\_\_\_\_

CC #: \_\_\_\_\_

Exp. Date: \_\_\_\_\_ CVV (security code): \_\_\_\_\_ Billing Zip Code: \_\_\_\_\_

Visa      Master Card      American Express      Discover      Debit Card

By signing below, I authorize Lexington Prescription Center to charge the credit/debit card using the information I have provided.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### **Vehicle Description**

Make: \_\_\_\_\_

Model: \_\_\_\_\_

Color: \_\_\_\_\_