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COVID-19 ANTIGEN TEST WAIVER

Patient Name: _____ **Date: _____**

Insurance: _____ **Account#: _____**

Type of Service: _____

This Waiver Form is our notice to inform you that at this time, we do not have a negotiated rate with your insurance company for the COVID-19 ANTIGEN TEST we are doing today. We will bill insurance for the test. If they are not reimbursing for the test at this time, you will be responsible for the payment of $40.00.

The COVID-19 Antigen Test is a in-office test (similar to the flu test) with results in 15 minutes that determines a current infection. This is not an antibody test.

I understand that I may be responsible for the $40.00 charge for the **COVID-19 ANTIGEN TEST**

_____ _____
Signature **Date**

_____ _____
Relationship to Patient **Witness**