**COVID- 19 ANTIGEN TEST WAIVER**

**Adult's Name:**___________________________________ **Phone:**_____________________

**Child's Name:** ___________________________________ **Address:**___________________

**Race:** **Ethnicity:**

**Type of Service:** **<u>COVID-19 ANTIGEN TEST</u>**

I understand, (as the parent, relative, guardian, or caretaker) by signing this waiver, that Nova Pediatrics is performing this test as a courtesy to my family. I also understand and agree that Nova Pediatrics its physicians and nurse practitioners are not accepting me as a patient and are not responsible for any of my healthcare needs. I will seek medical care from my own PCP, based on the result of this test if needed, or any other medical need. I understand that this is not billable to my insurance company and agree not to bill my insurance for the test.

I understand that if there is a positive COVID-19 result, there is mandatory reporting to government agencies, and the result will be reported.

The COVID-19 antigen test is a viral test that tells you if you have a current infection. I understand that COVID-19 testing is not 100% accurate. I understand that test result will be available to me through email or paper copy only and that the physicians and nurse practitioners of Nova Pediatrics are not reviewing the results of this test.

If I am not feeling well or have concerns or questions about the result of this test, I will consult my own healthcare provider.

I acknowledge that the service fee is a noncovered service, I cannot bill insurance and I am responsible for the $75 service fee.

________________________________ ________________________________
**Signature** **Date**

Your COVID result is: Negative Positive

If you have any concerns, follow up with your primary care provider or consult the CDC guidelines:
https://www.cdc.gov/coronavirus/2019-ncov/if-you-are-sick/steps-when-sick.html