



Ascent Urgent Care
& Walk-In Clinic

COVID -19 Consent Form

Today's Date: _____

Please Read and Clearly Print Out Entire Form

Exposure date: _____ Patient Gender: Male Female
Symptoms: _____

Patient Information

Patient First Name: _____
Patient Middle Initial: _____
Patient Last Name: _____
Date of Birth: _____
Marital Status: _____
SS# (Age 18 and up): _____
Patient Phone: _____
Patient Email: _____

Permanent Mailing Address:

Number & Street: _____
City: _____ State: _____ Zip Code: _____
Emergency Contact Name: _____
Emergency Contact Phone: _____
Emergency Contact Relation: _____

Reason for the test:

Symptomatic Travel School Work
 Other

Please Checkbox All Test Being Completed

15 minutes Rapid Nasal Test Sample
\$100 cost per test/ Covered by Insurance

15 minutes Rapid Test Sample
\$75 cost per test/ Covered by Insurance

PCR 48-72 Hour Test Sample (Nasal)
Insurance Covered
\$175 cost per test/ Covered by Insurance
Sample is Sent North West Labs. You Will
Receive an Email that Says: Do Not Reply
from North West Labs: Specimen

Insurance Information – MUST BE FILLED OUT!

Primary Insurance: _____ Relationship to Patient: _____
Subscribers Name: _____ Date of Birth: _____

Dear Patient,

The staff of Ascent Urgent Care & Walk-In Clinic provides professional health services. Due to many changes in insurance policy, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. It is your responsibility to know your individual coverage. A charge of \$35.00 will be applied to any account that is sent to collections. A \$25.00 fee will be incurred for any returned checks. Please remember your insurance policy is between you and your company and not with the Physician. For Work-related injuries, if your employer or the Workman's insurance does not pay, you the patient will be responsible for any charges incurred. By signing below, you hereby authorize your insurance benefits to be paid directly to Ascent Urgent Care & the on-staff physicians, realizing that you are responsible to pay non-covered services, and you hereby authorize the release of pertinent medical information to the insurance carriers. Receipt of HIPAA (Health Insurance Portability and Accountability Act) Privacy Notice Ascent Urgent Care is committed to maintaining the integrity of your protected health information and complies with all applicable state and federal regulations. In support of our policy of complying with all applicable regulations, Ascent Urgent Care provides patients with the HIPAA Notice of Privacy Rights. I acknowledge receipt of the Notice of Privacy Rights with detailed information about how Ascent Urgent Care may use and disclose my protected health information with my permission. I understand that Ascent Urgent Care reserves the right to change the privacy notice and that a copy of the revised notice will be made available to me. While not required in order to receive treatment at Ascent Urgent Care, we are obliged under federal regulations to ask that you sign an acknowledgement of the HIPAA Privacy Notice being made available to you. (Refusal to sign does NOT prevent the patient from being treated

Signature of Patient or Parent/Guardian: _____ Date: _____

HOWELL
1255 East Grand River
Howell, MI 48843
Ph: (517) 545 -7400
Fax: (517) 545- 7477

SALINE
140 S Industrial
Saline, MI 48176
Ph: (734) 316 -2268
Fax: (734)-236-6030

FENTON
17100 Silver Parkway, Suite B.
Fenton, MI 48430
Ph: (810) 936 -0040
Fax: (810) 936- 0041

www.ascenturgentcare.com
SALINE: aucsalinefax@gmail.com
HOWELL: auchowellfax@gmail.com
Fenton: aucfentonfax@gmail.com