RECEIPT

Tax ID: 80-0807886
www.medphysicalsplus.com
Email: labs@medphysicalsplus.com
T (907)5617587

Locations:

4141 B St. Suite 210 Anchorage, AK 99503
CLIA ID Number: 02D2200295

185 E. Nelson Ave Ste 2 Wasilla, AK 99654 CLIA ID Number: 02D2200299

1600 Salmon Creek Ln. Juneau, AK 99801 CLIA ID Number: 02D2238014

600 University Ave. Ste. 2B Fairbanks, AK 99709
CLIA ID Number: 02D2200297

36275 Kenai Spur Hwy. Ste. 2 Soldotna, AK 99669
CLIA ID Number: 02D2200296

Date of Service:_______________________________

Name: ______________________________________ DOB: ____________________________

Address: ____

Email: ____ Phone:___________________________

Passport #: ____________________________________ Destination: ______________________

Panabios ID (if applicable, for Trusted Travel Program; for travel to Africa): ________________________

Billing Acknowledgement:

I acknowledge that MedPhysicals Plus, LLC is not a physician's office and DO NOT bill insurance. I understand that MedPhysicals Plus, LLC provides a walk in lab test services and the tests received are by my request. The COVID diagnosis and COVID test CPT codes provided below are available online and is shared by MedPhysicals only as a courtesy. I also recognize that the services, provided to me today may or may not be reimbursed by my insurance company.

Signed: ____ Date: ________________________________

COVID-19 TESTING SERVICES

Diagnosis Code: Z11.52
Dr. William Herold NPI #: 1326187055

Test Codes:

	Service	**Price**	**CPT Code**
	Rapid Antigen	$209	87301
	Rapid NAAT	$275	87635
	Rapid RT-PCR	$275	87635
	RT-PCR/Flu/RSV	$290	87637
	Lab- Based PCR	$199	U0003

	Service	**Price**	**CPT Code**
	Antibody Test	$149	86769
	Immune Response Panel	$199	86769
	Phlebotomy Fee	$35	99195
	Indv. Mobile Fee	$50	
	Group Mobile Fee	$100	

ATTENTION INSURANCE PROVIDER - ASSIGNMENT OF BENEFITS:

I DO NOT authorize payment of services to be made to MedPhysicals Plus, LLC. Payment for the services indicated above have been paid in full to MedPhysicals Plus, LLC. This provider does not accept assignment for services provided. I request payment/reimbursement to be payable directly to the member.

Signed: ____ Date: ____________________________

Party Responsible for Payment:

- o Self; will provide Credit/ Debit Card
    - o Last four # of card _____________
- o Self; will pay with Cash
- o Employer/ third party
    - o Name of payor and contact information _______________________________

INFORMATION ABOUT YOU

Have you had any of the following symptoms in the last 14 days?

- Fever- temperature greater than or equal to 100.4 F? __________
- Persistent dry cough? __________
- Been in contact with a COVID-19 patient? __________
- Experienced shortness of breath? __________
- Been in contact with someone who has tested positive for COVID-19? __________
- Have you had any other flu like symptoms? __________
- Are you a woman who is pregnant or nursing? __________
- Do you have asthma, COPD, emphysema, cancer, diabetes, heart conditions, recurrent pneumonia or are you immunocompromised, other (specify)? ___________________________
  ____

DEPT. OF HEALTH REPORTING- Information Required for Infectious Disease

Race:_______________ Ethnicity:_______________

GIVE YOUR CONSENT

(Please check every single paragraph to confirm consent.)

______ I consent to testing and laboratory analysis by MedPhysicals Plus, LLC. My results and the information provided by me may be reported to the ordering physician, the person or entity arranging this testing (which may include, without limitation, a current or prospective employer), any of my or their designees, and public health authorities in accordance with applicable law. I consent to receiving email, text messages, and phone calls at the email address and phone number provided by me. My results may be reported to me through any of the foregoing means or any other reasonable mechanism, including web-based applications, at any time as my results are available. Any results I receive are for informational purposes only and do not constitute a medical diagnosis. It is my sole responsibility to seek and obtain medical and other advice relating to this testing and any results I receive. I consent to my information and results being shared with providers of the Physician Services.

______ I understand that there are possible risks associated with blood draws, saliva and nasopharyngeal swab specimen collection, including, without limitation, infection, discomfort, and bruising. I understand these risks may not be all-inclusive and that other more remote risks may be involved. As with all laboratory tests, there is a chance of a false positive or false negative result. By initialing, I am agreeing to all of the terms of this Notice, Consent, and Release for COVID-19 Testing. To the fullest extent permitted by law, I release and forever discharge MedPhysicals Plus, LLC and the laboratories they employ to perform the testing and analysis and the person or entity arranging this testing from liability relating to the Physician Services and the collection, testing, and reporting of information described herein.

______ MedPhysicals Plus, LLC requires payment at the time of service and by signing below I agree that I am financially responsible for all services I may acquire from my visit(s). I acknowledge that MedPhysicals Plus does not bill any health insurances. I understand that a detected/positive test DOES NOT mean that I am immune to COVID-19 and that I will never catch the virus again. In consideration for such services being rendered on my behalf, I hereby RELEASE MPP, its officers, agents, and employees, from any and all claims which I might otherwise have due to such results being made so available. I hereby CONSENT NOT TO FILE ANY ACTION at law or in equity against company connection with the results of such screen being made so available, and I hereby agree to INDEMNIFY and SAVE HARMLESS MedPhysicals Plus, LLC, the laboratory testing service, their respective officers, agents, and employees from all damages, expenses, reasonable attorney's fees, and costs of court which they or any of them may suffer or incur, jointly or severally, due to the results of such screen being made so available.

______ **TESTING FOR TRAVEL PURPOSES**: I understand that it is my sole responsibility, as the traveler and client, to research which COVID-19 test is required for where I am traveling to. I understand that MedPhysicals Plus, LLC will conduct the COVID-19 testing that I request. I acknowledge Lab-based tests can take up to 72 hours and MedPhysicals does not guarantee the result report will be sent sooner than 72 hours. By signing below, I release the right to a refund if I, the client, order the wrong test or have the test completed outside of the required time limit for the places I am traveling to.

______ **CONSENT TO RELEASE RESULT TO EMPLOYER**: I give consent for my test result to be released to

____.

______ I am at least of 18 years of age or the legal guardian of the donor with authority to consent on their behalf. I AGREE TO ALL OF THE TERMS OF THIS NOTICE, CONSENT AND RELEASE FOR COVID-19 TESTING.

Signed: ____ Date:__________________________