



Today's Date: _____

 First Name: _____ Last Name: _____ DOB: ____/____/____
PRINT PRINT MM DD YYYY

Circle your answers:

1. Are you doing this test for traveling purposes?	YES  You DO NOT qualify for FREE testing. Price for test is \$150.00	NO – Continue to next question
2. Have you experienced any of the symptoms in the list below in the past 48 hours?	<ul style="list-style-type: none"> • fever(R50.9) • shortness of breath or difficulty breathing(R06.02) • fatigue(R53.82) • muscle or body aches(M79.10) • new loss of taste or smell(R43.9) • sore throat(R07.0) • congestion or runny nose(R09.81) • nausea or vomiting(R11) • cough(R05) • headache(R51.0) • diarrhea(R19.7) 	NONE – Continue to next question
3. Have you been in close physical contact in the last 14 days with:	<ul style="list-style-type: none"> • Anyone who is known to have laboratory-confirmed COVID-19(Z20.822) • Anyone who has any symptoms consistent with COVID-19(Z20.822) 	NO – Continue to next question
4. Did you test positive for COVID-19 in the past 14 days?	YES(Z86.16)	NO – Continue to next question
5. In the past 14 days have you been to any of these public places without wearing a proper personal protection like a face mask, etc?	<ul style="list-style-type: none"> • retail/grocery stores(Z20.822) • restaurants/bars(Z20.822) • public parks(Z20.822) • place of worship(Z20.822) • public transport/rideshare(Z20.822) 	NO – Continue to next question
6. In the past 14 days have you spent time with more than 5 strangers without wearing a proper personal protection like a face mask, etc?	YES(Z20.822)	NO  You DO NOT qualify for FREE testing. Price for test is \$150.00

EMAIL	
-------	--

PHONE	
-------	--

I, the undersigned insured, hereby authorize and instruct that all payments of benefits under my policy for laboratory services furnished to me, my dependent, or insured under my policy be made directly to Magic Owl Laboratories, Inc or its assignee. I further acknowledge that TRIM CARE, Inc may be an out-of-network provider with my insurance provider and that my insurance may only cover a portion of the total bill that I may be responsible for. I agree to cooperate with Magic Owl Laboratories, Inc on any collections or appeals process and that I am responsible for paying any co-pays and deductibles not covered. In addition, I hereby authorize the release of my protected health information to Magic Owl Laboratories, Inc representatives, its agents, clinical consultants, ordering providers and I authorize and release Magic Owl Laboratories, Inc, their agents, officers, employees and representatives from any and all liability that may arise as a result of disclosure of any protected health information to other third parties for reimbursement. I further authorize a performing CLIA Laboratory to release the results of this testing to the treating authorized healthcare provider or facility. With this assignment, I am requesting that Magic Owl Laboratories, Inc instructs my insurance carrier to forward all payments for lab services to Magic Owl Laboratories, Inc directly or its assignee. I understand that some insurance companies may send payments directly to me, my dependent, or persons that are insured under my policy. I agree to endorse and forward those payments to Magic Owl Laboratories, Inc or its assignee immediately. If I do not forward these payments to Magic Owl Laboratories, Inc immediately I may be responsible for all reasonable costs of collection; including attorney's fees. I further acknowledge that keeping insurance records of Magic Owl Laboratories, Inc may potentially have severe civil and criminal consequences. I acknowledge receipt of a copy this Assignment and Release. A photocopy of this authorization shall be considered as effective and valid as the original. I certify that my responses are true and correct.

Signature: _____