MEDHERO Advanced Urgent Care

Patient Name:

Patient DOB: / /

Todays Date: _____

Election to pay for Rapid COVID-19 Antigen Test in lieu of Covered PCR Test

NOTE: By executing this election after electing to receive the Rapid Covid-19 Antigen Test, you agree to pay in full the fee for the Rapid COVID-19 Antigen Test and hereby direct the Provider to not submit a claim to your insurance carrier for reimbursement. You also acknowledge there is a polymerase chain reaction ("PCR") Covid-19 Test available that is offered by the Provider and may be a covered cost.

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the Rapid Covid-19 Antigen Test in lieu of the covered PCR Test.
  Note: If you choose Option 1 you are agreeing to pay for the test in full regardless of the insurance you have.

OPTIONS:	**Check only one box. We cannot choose a box for you.**
☐ **OPTION 1.** I want the **Rapid Covid-19 Antigen Test and hereby direct the above referenced provider not to bill my insurance carrier**. I will be asked to pay the fee for the Rapid Covid-19 Antigen Test now. **$149.00**	
☐ **OPTION 2. I DO NOT WANT the Rapid Covid-19 Antigen Test** and instead want the **PCR Covid-19 Test, the results of which are not available same day.** I may be asked to pay the fee for the PCR Covid-19 Test now, but I also want my insurance carrier to be billed for an official decision on payment. I understand that if my insurance carrier doesn't pay, I am responsible for payment. If my insurance provider does pay, you will refund any payments I made to you, less co-pays or deductibles.	

Signing below means that you have received and understand this notice. You may request a copy.

Signature:	**Date:**