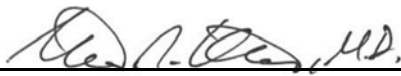




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www.inspirediagnostics.com CLIA #: 05D2203452

ACCOUNT INFORMATION				PATIENT INFORMATION			
GROUP/PRACTICE NAME				Last Name		First Name	
Address				Date of Birth (MM/DD/YY)		Sex <input type="checkbox"/> M <input type="checkbox"/> F	
Address				Address			
City		State	ZIP	City		State	ZIP
Phone #:		Fax #:		Phone #:		Email:	
				Race: <input type="checkbox"/> White <input type="checkbox"/> Latino <input type="checkbox"/> Asian <input type="checkbox"/> African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Multi-Race <input type="checkbox"/> Native Hawaiian/Other Pacific Islander <input type="checkbox"/> Other			
Ordering Physician Steven Kim, MD				Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic			
The ordering physician must sign his/her name and indicate the date the test is ordered. The signature constitutes as a certification, that with respect to tests reimbursed by Medicare, Medicaid, or other third-party payers that the testing is medically necessary, and the results will be used in the management of the patient.				I authorize Inspire Diagnostics to release the results of this testing to the treating physician or facility. I have read and understood the ABN provided with this form.			
<input checked="" type="checkbox"/>  Physician Signature _____ Date _____				<input checked="" type="checkbox"/> _____ If Patient under 18, Parent/Guardain Signature _____ Date _____			
				<input checked="" type="checkbox"/> _____ Patient Signature _____ Date _____			
				Insured's Name (If different from patient)			
SPECIMEN TYPE				Primary Insurance Name & Plan / Workers Comp. Carrier			
<input type="checkbox"/> Nasopharyngeal <input type="checkbox"/> Oropharyngeal <input type="checkbox"/> Nasal <input type="checkbox"/> RNA Collection Date: _____ Time: AM/PM Collector Name: _____				Address (Insurance)			
				Policy #		Group/Plan/Book #	
TEST REQUESTED							
<input type="checkbox"/> COVID-19 Only (SARS-CoV-2 Molecular Assay) <input type="checkbox"/> COVID-19 Only (SARS-CoV-2 Antigen Test) <input type="checkbox"/> COVID-19 Only (SARS-CoV-2 Antibody IgM/IgG Test)				<input type="checkbox"/> Respiratory Pathogen Panel w/ COVID-19 Test Influenza AB Streptococcus A			
ICD-10 CODES							
COVID-19 CODES ARE LISTED BELOW AND <u>MUST</u> BE CHECKED OFF							
<input type="checkbox"/>	R05	COUGH					
<input type="checkbox"/>	R06.02	SHORTNESS OF BREATH					
<input type="checkbox"/>	R50.9	FEVER UNSPECIFIED					
<input type="checkbox"/>	Z03.818	SUSPECTED EXPOSURE TO COVID -19					
<input type="checkbox"/>	Z20.828	KNOWN EXPOSURE TO COVID-19					
<input type="checkbox"/>	OTHER						
<input type="checkbox"/>	OTHER						