Cole Diagnostics **Testing Location: 7988 W Marigold Street, Boise, ID 83714**
COVID-19 Testing **208-472-1082 www.colediagnostics.com**

Patient Information:

First Name:	Last Name:
Date of Birth:	Gender: M or F
Street:	Cell Phone:
City, State, Zip:	Email Address:

Provider Information:

Provider Name:	Phone Number:
Practice Name:	Fax Number:

Provider Signature: _____ Date: _____

Patient History: (Check any that apply)

	Fever above 100.4 degrees (R50.9)	Date Symptoms Began
	Cough (R05)	
	Shortness of breath (R06.02)	
	Sore throat (J02.9)	
	Lost sense of taste or smell (R43.8)	
	Diarrhea (R19.7)	
	Nausea (R11.0)	
	Nausea and vomiting (R11.2)	
	Vomiting (R11.11)	
	Loss of appetite (R63.0)	
	Fatigue (R53.83)	
	Headache (R51)	
	Chills without fever (R68.83)	
	Chills with fever (R50.9)	
	Muscle pain (M79.10)	
	Shortness of breath (R06.02)	
	Breathing abnormalities (R06.89)	
	I have had close contact with someone who tested positive. (Z20.828)	
	When was your exposure?	
	I need a test for travel (Z03.818)	
	I need a test to return to work ((known exposure Z20.828, asymptomatic possible exposure Z03.818)	
	I have had a nasal or throat swab PCR test performed?	Date: Result?
	Are you a healthcare worker?	
	Are you being tested prior to a surgery and currently have no symptoms? (Z01.818, Z20.828, Z11.59)	
	Other symptoms (please describe):	

Test(s): (We'll help you choose)

	COVID nasal swab by PCR
	COVID IgM antibody test (blood draw)
	COVID IgG antibody test (blood draw)

Agreement to seek care:
I agree to seek care from an appropriate care provider for any symptoms I may be experiencing. Cole Diagnostics is responsible for accurately testing my sample and communicating results, but not providing medical advice. If I don't have a primary care provider, Cole Diagnostics may suggest some available options, but it is my responsibility to contact a provider.

Billing (Please choose and initial one):

Option 1:	Please bill my insurance as listed below. I acknowledge the possibility that my insurance company will not cover the cost of testing. In that case, I will be billed the lesser of the amount determined by my insurance company or $60 (for antibody) or $120 (for PCR).
Option 2:	I agree to pay for my test today. $50 for IgG/IgM antibody tests, $30 for IgG antibody only, or $95 for the PCR test.
Option 3:	My employer has authorized this testing, has sent an account setup form to Cole Diagnostics, and will pay for my test(s). Employer Name: _____ Manager Name: _____ Phone Number: _____

Insurance Information: (If option 1 above is selected)

Insurance Company:	Group No:
Subscriber Name:	Subscriber ID:

HIPAA Release: (to enable email results)
I would like to have my report emailed to me at the email address listed above. I understand that email reporting may not comply with HIPAA (Health Insurance Portability and Accountability Act) requirements for the protection of my health information, and that this places some protected health information at risk. Cole Diagnostics will take every reasonable precaution to prevent this exposure, and also acknowledges that their email server and many others are not considered HIPAA compliant.

If I prefer not to email, I can return to the laboratory and pick up a printed copy. All reports will be available 72 hours after the samples are collected (Monday through Friday 8:00 AM to 5:00 PM only).
Please select one:

Yes	Please email me my laboratory result
No	I'll come pick up my laboratory result

Sharing results with your employer:
If your employer is requiring and/or paying for your testing, they may request a copy of your results directly from us. We need your permission to release your results to your employer.
Please select one:

Yes	I consent to Cole Diagnostics releasing results to my employer
No	Cole Diagnostics may not release results to my employer

Patient Acceptance:
I hereby authorize this testing to be performed on my sample, agree to the billing option I have selected, understand the role of Cole Diagnostics in my healthcare, and I request the laboratory to report my results according to my selection above.

Patient (or responsible party) Signature: _____ Date: _____

Cole Diagnostics Use Only:
Sample Collection:

Collection Date:	Collection Time:	Phlebotomist:

Payment Status (please circle one): Bill Insurance Bill Employer Bill Client/Provider Paid TOS