Covid-19 Antibody

Name_____ Birthdate_____

Address_____

Telephone number_____

Payments must be made prior to collection of the sample.

Test request (circle):

Covid-19 IgG antibody $60

Paid: Cash ◯ _____ Check ◯ #_____ Credit card/other ◯ _____

I HAVE READ AND UNDERSTAND THE FOLLOWING:

- A parent/legal guardian must accompany anyone under age 18.
- Results will not be forwarded to your Primary Care Provider.
- The provider signing below will not have access to the results. It is the responsibility of the customer or legal parent/guardian to follow up on results with their Primary Care Provider.
- This test will indicate previous exposure to the SARS-CoV-2 virus and does not indicate if a current infection is present.
- Third Party Payment or Reimbursement: To the best of our knowledge and belief, Immunity Laboratory Testing is not reimbursed by any health insurance company or by Medicare, Medicaid or any other city, state or federal program. **You may NOT submit a request for payment or reimbursement of the charges from Immunity Laboratory Testing to any health insurance company or to Medicare, Medicaid or any other city, state or federal program. Payment from an HSA account is acceptable.**

X _____ _____

Signature of Customer or Parent / Legal Guardian of Minor **Date**

Provider signature Dr. David Sloan MD (see below)

WdCflmo