Self Pay Attestation/Consent Agreement

This is a fee for service/cash only elective test for travel and will not be billed to your insurance.

Patient Name: ______________________ **Date:**_____/_____/________.

Date of Birth: ______/______/_________. **SSN:** _______-_______-_______

I attest that:

- I understand it is my right to restrict disclosure of certain health information and pay out-of-pocket in full for a particular medical service under federal privacy regulations. Title 45, Code of Federal Regulations, Part 164.522
- I am choosing to exercise my right under the above regulation.
- I am electing to pay out of pocket for the Rapid testing for COVID-19 offered by AFC Urgent Care.
- I acknowledge and understand that AFC Urgent Care will not be submitting a claim to my insurance for this service.
- I will notify AFC Urgent Care if I have any questions about this attestation.
- I will not submit this charge to my insurance for reimbursement.

____ ____________________________

Patient Signature **Date**