The Kidz Docs

Pediatric & Adolescent Medicine

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COVID-19 RAPID ANTIGEN TEST WAIVER

Patient Name____Date:_______________________________________

Health Insurance Name____

This waiver form is our notice to inform you that at this time, we do not have a negotiated rate with your insurance company for the COVID-19 RAPID ANTIGEN TEST we are doing today. We will bill insurance for the test. If they are not reimbursing for the test at this time, you will be responsible for the payment of $45.00.

The COVID-19 Rapid Antigen Test is a test that tell you if you have a current active infection.

I understand that I may be responsible for the $45.00 charge for the RAPID COVID-19 ANTIGEN TEST.

_______________________________ _______________________________
Signature Date

_______________________________ _______________________________
Relationship to Patient Witness