Cedar Park Pediatric & Family Medicine
Southwest Pediatric Associates
Treehouse Pediatrics

Non-Patient COVID-19 Self Pay Waiver

Name (Last, First): _____
.
Date of Service: _____

Service Received: Rapid COVID-19 Test

Cost of Service: $99

I agree that I am not establishing a patient-provider relationship by receiving this service and that I will need to follow up with my primary care provider.

_____

Signature Date