Cedar Park Pediatric & Family Medicine
Southwest Pediatric Associates
Treehouse Pediatrics

Rapid COVID-19 Test

Patient Name (Last, First): _____

Date of Birth: _____
.
Date of Service: _____

Provider: _____

Your provider has ordered a Rapid COVID19 test. As a courtesy to our patients we will file the charges associated with this test to your insurance carrier. However, this is not a guarantee that your insurance will pay for this test.

I agree to be financially responsible for any portion not covered by insurance for the costs associated with Rapid COVID19 testing not to exceed $49.00

All no shows will be assessed a fee of $49.00

_____

Signature Date