Family Rehab, Inc.
Inti Fernández, M.D.

PORTOFINO IV CENTER
901-A SW 87 AVE
MIAMI, FL 33174
TEL: 305-225-6266
FAX: 305-225-6296
INFO@FAMILYREHAB.US

Please read the following document carefully and sign:

a. I authorize this Covid-19 Test Center "Family Rehab" to acquire a nasopharyngeal sample and to examine the sample for the detection of Covid-19 as required by public health agencies.

b. I authorize my results to be communicated to any government agency or as required by law. I also authorize the communication of my positive results to airlines and cruise ships as required by Miami-Dade County Government. This authorization is valid for a period of one (1) year from the day it was signed.

c. I understand that a positive result is an indication that I should quarantine, wear a mask or cover my face so as not to infect others

d. I understand that this laboratory is not acting as my physician, and does not replace the need for a physicians care when required. I also accept responsibility for my results and what they mean. I agree to obtain a medical consultation with my physician to clarify any concerns I have, to obtain care / treatment if my condition worsens and I understand that like other diagnostic procedures, there is a possibility of a false positive or false negative test for Covid-19.

e. I understand that "Family Rehab" are in no way responsible if the client / patient does not arrive on time for their flight / misses it or is quarantined upon arrival at their destination. I understand that the responsibility for choosing the type of proof necessary for my destiny is mine and mine alone.

f. I understand that "Family Rehab" are in no way responsible if the client / patient does not arrive on time for their flight / misses it or is quarantined upon arrival at their destination. I understand that the responsibility to choose the type of test necessary for my destiny is mine and mine alone.

g. I understand and agree that "Family Rehab" do not provide cancellations or refunds once the test has been administered.I, the patient / client, have been informed of the purpose of the test, the procedures, the possible benefits and risks. I have also received a copy of this consent. I have been given the opportunity to ask questions before signing. I accept this Covid-19 test voluntarily, for my personal, business or travel needs

I, the undersigned, have been informed about the test purpose, procedures, possible benefits and risks, and I have received a copy of this Informed Consent. I have been given the opportunity to ask questions before I sign, and I have been told that I can ask additional questions at any time. I voluntarily agree to this testing for COVID-19.

Customer name

my full name

Name

my full name

Middle name

my full name

Last name

(123) 456-7890

phone:

male

Gender:

Client's date of birth

02-15-2022

Additional customer information

(123) 456-7890

Passport #

Fever

○Yes
◉ No

Cough (new onset or worsening of chronic cough) *

○ Yes
◉ No

Throat pain

○Yes
◉No

Difficulty breathing (dyspnea)

○ Yes
◉ No

Nausea *

○Yes
○No

Abdominal pain *

○ Yes
◉ No

Chills *

○Yes
◉No

Headache

○Yes
◉No

Muscle aches (myalgia)

○ Yes
◉ No

Fatigue *

○ Yes
◉ No

Runny nose (rhinorrhea) *

○ Yes
◉ No

Vomiting

○ Yes
◉ No

Diarrhea (3 loose stools / day) *

○ Yes
◉ No

Loss of smell *

○ Yes
◉ No

Loss of taste

○ Yes
◉ No

(123) 456-7890

Other specify

(123) 456-7890

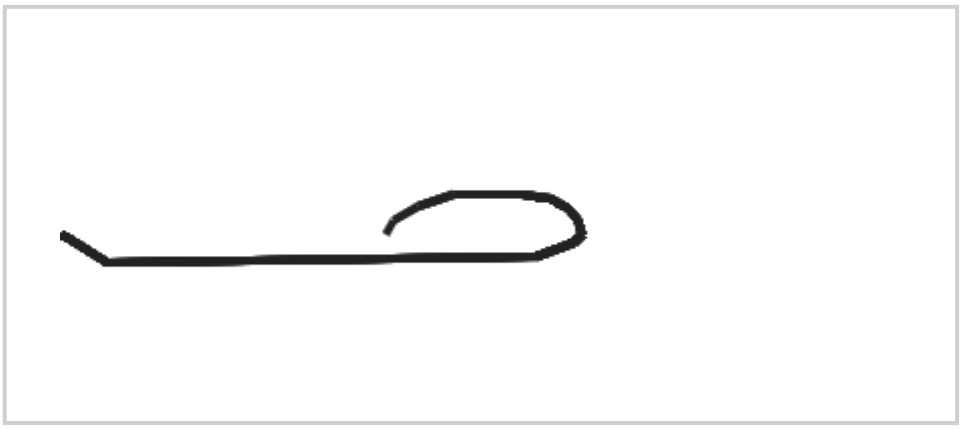
Date of onset of the symptoms

Lab test

Test type: nasal swab (PCR) / antigen / SARS-COV-2

Select the test

○ ANTIGEN
◉PCR
○RT-PCR
○PCR-24hrs
○RT-PCR 24hrs



Customer Signature

Customer Address

Address: **full street address**

Address2: **street address line number two**

Zip Code: **zip code or postal code**

State / Province: **state name**

Country: **United States**

Email address

me@mydomain.com

Email address

FLIGHT/CRUISE INFORMATION

Airline/CruiseLine*

Destination

Flight/Cruise #

Insurance Information

fd

Primary Insurance

cs

Policy Holder Name

fd

Relationship Patient

s

Policy Holder DOB

ff

Policy # / Member ID

sf

Group #

fd

Secondary Insurance

34

Policy Holder Name

fd

Relationship Patient

fs

Policy Holder DOB

fh

Policy # / Member ID

f

Group #

Electronic signature acceptance

☑ By checking ts box, you agree that your electronic signature will be used in place of your handwritten signature. If this is not what you want, you have the right to ask to sign a paper copy instead. By checking this box, you warve this right Upon acceptance, you may request in writing that we send you a paper copy of the electronic record. You will not have to pay anything for such a copy, and you do not need any special software or hardware to view it. Your acceptance of electronic signature for any document will remain in effect until such time as you notify us in veriting that you no longer wish to use electronic signature. The revocation of your acceptance will not entall any penalty for you Your acceptance of electronic signature for any document will remain in effect until such time as you notify us in veriting that you no longer wish to use electronic signature. The revocation of your acceptance will not entall any penalty for you Your acceptance of electronic signature for any document will remain in effect until such time as you notify us in veriting that you no longer wish to use electronic signature. The revocation of your acceptance will not entall any penalty for you