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

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

Please carefully read and sign the following Informed Consent:

a. I authorize this COVID-19 testing unit to conduct collection and testing for COVID-19 through a nasopharyngeal swab or blood draw, as ordered by an authorized medical provider or public health official.

b. I authorize my test results to be disclosed to the county, state, or to any other governmental entity as may be required by law. I also authorize the disclosure of my test results, in the case of a positive test result, to the airlines as required by the Miami-Dade Aviation Department. This authorization is valid for one (1) year from the date this authorization is signed. c. I acknowledge that a positive test result is an indication that I must self-isolate and/or wear a mask or face covering as directed in an effort to avoid infecting others.

d. I understand the testing unit is not acting as my medical provider, this testing does not replace treatment by my medical provider, and I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if my condition worsens.

e. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result.

f. Customer understands and acknowledges that Family Rehab and Communitel are not responsible in any way if the customer misses, is quarantine and/or is late to their flight. It is the ultimate responsibility of the customer to determine and confirm with the airline and/or destination country regarding which type of test is required. g. Customer understands and acknowledges that there shall be no cancellations and/or refunds given once the test is performed.

h. Customer understands and acknowledges that Family Rehab cannot guarantee that customers will receive their test results electronically due to possible spotty internet connections and email security protocols that may reject or send test results to a spam folder. Family Rehab highly recommends that each customer requests and obtains a printed copy of their test results. 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.

Name Of First Minor

my full name

Name

my full name

Second name

my full name

Last name

(123) 456-7890

Phone

Friends

Gender:

Client's date of birth

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 first symptoms

Lab test

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

Select the test

○ ANTÍGENO
○RT-PCR
○PCR-24hrs
○PCR-24hrs
○PCR

Customer Signature

Customer Address

Address: **street address line number one**

Address2: **street address line number two**

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

State / Province: **Alabama**

Country: **Afghanistan**

Email Address

me@mydomain.com

Email

FLIGHT/CRUISE INFORMATION

Air Lingus (EI)

Airline/CruiseLine*

as

Destination

sd

Flight/Cruise #

Parent Or Guardian Name

Name: **my full name**

Second name: **my full name**

Last name: **my full name**

Telephone **(123) 456-7890**

Gender: **male**

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