Due to the Health Insurance Portability and Accountability Act (HIPAA) or 1996, the following information must be filled out by each client annually.

In the event a family member(s) or caregiver(s) attends my visit(s), and is in the exam area at the time of my evaluation and/or treatment,

Please Check One -

○ YES ○ NO

I give MOBILE TESTING SOLUTIONS LLC, its affiliates (COVI-STAT, HYDRA-STAT, MEDIC-STAT), its providers and employees my permission to discuss freely my condition, treatment, or diagnosis with that person(s) present.

IV Therapy Solutions Clients Only:

_____I have informed the Technician of any known allergies to medications or other substances and of all current medications and supplements. I have fully informed the Technician of my medical history.

_____Intravenous therapy and any claims made about these infusions have not been evaluated by the U.S Food and Drug Administration and are not intended to diagnose, treat, cure, or prevnet any medical disease. These IV Therapy infusions ar not a substitute for your primary care physicians medical care.

_____I understand today's procedure:

1. Involves the insertion of a needle into a vein and injection of the prescribed solution
2. Alternatives to IV Therapy include oral supplements and/ or dietary and lifestyle changes
3. Risks of IV Therapy include but are not limited to:
    1. Occasional discomfort, bruising, and possible pain at the injection site
    2. Rare inflammation of the vein used during the infusion, phlebitis, metabolic disturbances and injury
    3. Extremely rare allergic reactions, anaphylaxis, infection, cardiac arrest and death

_____I am aware other unforeseen complications could occur. I do not expect the Technician to anticipate and or explain all risks and possible complications of today's therapy. I rely on the Technician to exercise judgement during the course of treatment with regards to my procedure. I understand the risks and benefits of the procedure and have had the opportunity to have all my questions answered. I understand I have the right to consent to or refuse any propsoed treatment, at any time prior to its performance.

COVID-19 Testing Clients Only:

_____I understand, in the event my testing is sponsored by and / or required by my employer, I give MOBILE TESTING SOLUTIONS LLC, its affiliates, its providers and employees my permission to discuss my test results with my employer.

In the event we need to contact you:

May we leave a detailed message on your cell phone:

○ YES ○ NO

May we leave a detailed message on your work phone:

○ YES ○ NO

May we leave a detailed message on your home phone:

○ YES ○ NO

With whom may we discuss information about your care, treatment or diagnosis?

_____ Relationship _____

_____ Relationship _____

With whom should we contact in case of any emergency?

_____ Relationship _____

Street Address _____

City _____ State _____ Zip _____

Phone _____

By signing below, I acknowledge that I have been provided access to, a copy of this facility's ***Notice of Privacy Practices***. I understand the information provided on this form and agree to all statements made above, all procedures have been adequately explained to me, and I authorize and consent to the performance of procedures. I release MOBILE TESTING SOLUTIONS LLC, its affiliates (COVI-STAT, HYDRA-STAT, MEDIC-STAT), its providers and employees from all liabilities for any complications or damages associated

_____ _____

Client Signature Date