



OFFICE USE ONLY

PCR + - RAPID + - TRAVEL

Last Name: _____ First Name: _____ MI: _____

Date of Birth: _____

Phone Number: _____

Email: _____

Address: _____

Subscriber Name: _____ Subscriber DOB: _____

By completing this document, I give my consent to treat.

By completing this document, I agree to pay unpaid insurance balances including collection fee.