COVID-19 Pre-Treatment Screening and Attestation

DOCTORS ON CALL

3350 LOWER HONOAPIILANI RD, STE 211 LAHAINA, HI 96761 Ph: 808-667-7676

Name:_____**Birthdate**_____**Phone**_____

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☐ ☐ Do you have a cough? _____How Long_____

☐ ☐ Do you have fever? _____How Long_____

☐ ☐ Do you have any of these symptoms: Body aches_____ Fatigue_____ Shortness of breath_____

Loss of smell_____Other_____How Many Days_____

☐ ☐ Have you or someone in your household recently traveled outside of Hawaii in the past three weeks?

Where _____Date of Arrival to Maui_____

☐ ☐ Have you or someone in your home been in contact with someone who tested positive for COVID-19?

Who_____Where_____Date Exposed _____

☐ ☐ Are you a health care worker? Where_____

☐ ☐ Have you had close contact in the past 14 days with a suspected or lab confirmed COVID-19 patient?

Who_____Where_____Date Exposed_____

****If you answered No to all please state reason for test**_____

Signature :_____Date: _____

We assume no responsibility for exposure to SARS-CoV, SARSCoV-2 [COVID-19] after this test result.

To be completed by Provider:

TEMP:	HR:	O2:

Test result Negative _____
Tested negative for severe acute respiratory syndrome coronavirus eg, SARS-CoV, SARSCoV-2 [COVID-19]

Test Result Positive: _____
Detected antigenic proteins SARS-CoV-2 [COVID-19].

Provider Name: Shannon Richards, FNP-BC James Barahal, MD Norman Estin, MD

Provider Signature: _____Date_____

DOCTORS ON CALL**MAUI'S URGENT CARE

PATIENT NAME:_____Male_____Female_____
First MI Last

Birthdate:_____SS#:_____

Mailing Address:_____

ZIP/City/State_____

Home Phone: _____Cell Phone:_____

Insurance Carrier: _____ **ID Number** _____

Group Number _____

Secondary Insurance Carrier _____ **ID Number** _____

Group Number _____

Email _____

INSURANCE & BILLING INFORMATION: We participate with: **HMA, HMAA, UHA, PSWA, MEDICARE, ALL KAISER PLANS, BLUE CROSS PPO PLANS, HAWAII HMSA PPO/HMO PLANS. (no quest) Mainland BLUE CROSS HMO** members may need precertification prior to visit. We do not accept out of network MEDICARE ADVANTAGE PLANS or MEDICAID.

UHA MEMBERS: Plan will not reimburse for the test. We will submit to them for consideration however $83 payment is required at the time of service. Please contact your plan for additional information. If the plan retroactively processes the test your credit card will be refunded.
Initial:_____

Credit card information is required for all patients as we are unable to verify insurance eligibility at drive through/pop up clinics. If you are not covered at the time of your visit, we will charge your card for the cost of the test.

Cardholder's Name _____

Credit Card Number _____

Expiration Date _____

Sec Code _____

Charge Amount _____ (each test is $83)

Authorized Signature _____

Additional notes. If you are paying for more than one test list all patients names

_____

_____

Billing Address if different than mailing: _____

I hereby authorize the payment of medical benefits to Ka'anapali Medical Services, dba Doctors On Call for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.

I further agree to pay all collections costs, attorney fees, and other collection costs that may be incurred to enforce the collection of any amounts outstanding.

I hereby authorize Doctors On Call to release any medical information necessary to complete and process my insurance claims and to treat me and use my personal information for health care operations.

Patient OR Insured's Signature (If a Minor, Responsible Party Signature)

_____ **Date**_____