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**____________

Y N

☐ ☐ 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.

<u>To be completed by Provider:</u>

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 $63 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.________

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 ______________________

Card Number ______________________

Expiration Date ______________________

Sec Code ______________________

Charge Amount ______________________ (each test is $63)

Authorized Signature ______________________

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

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Billing Address if different than mailing: ______________________

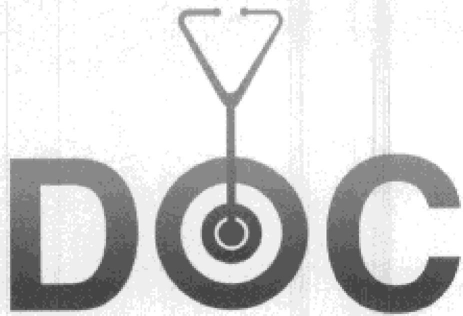
I hereby authorize the payment of medical benefits to Ka'anapali Medical Services, dba Doctors On Call for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.

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**______________________



www.doctorsoncallmaui.com
808-667-7676

Credit Card Authorization

Date ______________

Patient Name ____

Billing Address ____

Cardholder's Name ____

Card Number ____

Expiration Date ______________________

Sec Code _____________________

Charge Amount ________________________________ (each test is $63)

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