

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 _____

Email: _____ (to send PCR/rapid results)

COVID -19 Symptoms Circle Y or N and how many days you have had symptoms on the line following:

Cough: Y N How Long: _____ Fever: Y N _____ Shortness of breath Y N _____

Fatigue: Y N How Long: _____ Loss of taste or smell: Y N _____ Sore Throat: Y N _____

Body Aches: Y N _____ Other: _____ How Long: _____

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

Where _____ Date of Arrival to Maui _____

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

Who _____ Where _____ Date Exposed _____

Are you a health care worker? Y N Where: _____

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

Who _____ Where _____ Date Exposed _____

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

**** I consent to having my test results delivered via telemedicine platform****

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:
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Rapid Test result Negative: _____

IgG/IgM Rapid Test Negative: _____

Rapid Test Result Positive: _____

IgG/IgM Rapid Test Positive: _____

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

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** _____