PCR Lab_____ RAPID_____ SELF_____ INS_____

DOCTORS ON CALL COVID-19 Pre-Treatment Screening and Attestation 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 in the line following:

Cough: Y N How Long:_____ Fever: Y N _____ Body aches: Y N _____

Fatigue: Y N _____ Loss of smell: Y N _____Shortness of breath: 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 close contact with someone who tested positive for COVID-19? Y N

Who_____ Where Exposed_____ Date Exposed_____

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

****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:

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: _____
First MI Last

Birthdate: _____ Male _____ Female _____

Mailing Address: _____

ZIP/City/State _____

Home Phone: _____ **Cell Phone**: _____

Email _____

Primary Insurance Carrier: _____ **ID Number** _____

Secondary Insurance Carrier _____ **ID Number** _____

Business Account Name:(if applicable) _____

INSURANCE & BILLING INFORMATION: We participate with: **HMA, HMAA, UHA, PSWA, ORIGINAL MEDICARE, ALL KAISER PLANS, BLUE CROSS PPO/HMO PLANS, HAWAII HMSA PPO/HMO PLANS. (no quest) MDX Humana,** We do not accept out of network MEDICARE ADVANTAGE PLANS or MEDICAID.

UHA MEMBERS: Plan will not reimburse for the test without symptoms or community exposure (no work exposure). We will submit to them for consideration however $93 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 during high volume. If you are not covered at the time of your visit, we will charge your card for the discounted cost of the test, $93. If an insurance claim has processed the copays and or deductibles will be charged and receipt sent to email on file. Initial _____

Cardholder's Name _____

Credit Card Number _____

Expiration Date _____

Sec Code _____

Charge Amount _____ $93.00 **(each test is $155 discounted 40% if no insurance will be filed. Staff will not assist with out of network claim filing) Initial _____**

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** _____