

DOCTORS ON CALL** MAUI'S URGENT CARE
3350 LOWER HONOAPIILANI, STE 211 LAHAINA, HI 96761*** 22 HANA HWY, KAHULUI HI 96732

PATIENT NAME: _____
First MI Last

Birthdate: _____ **Male** **Female**

Mailing Address: _____

ZIP/City/State _____

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

Email _____

Business Account Name: (if applicable) _____

PRIMARY INSURANCE & BILLING INFORMATION: We participate with: HMA, HMAA, UHA, PSWA, ORIGINAL & RAILROAD 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. Secondary plan name and ID enter in below.

UHA MEMBERS: Plan will not reimburse for the test without symptoms or community exposure (no work exposure). \$93 payment is required at the time of service for work, travel or curiosity testing. Please contact UHA toll free at 800 458-4600 for additional information. **Initial:** _____

Check Plan (s): ORIGINAL & RR MEDICARE _____ KAISER _____ LOCAL HMSA _____ BCBS MAINLAND _____ UHA _____ HMAA _____
HMA _____ PSWA _____ HUMANA HAWAII _____ OTHER _____ QUESTION? TEXT OR CALL: 808 365 4795

ID Number: (Include all letters and dashes:) _____

Secondary Insurance Carrier _____ **ID Number** _____

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 credit 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/mail 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):

Sign: _____ **Date** _____

SELF _____ INS _____ Business Acct: _____ Iphone _____ Doxi _____

PCR Lab _____ RAPID _____ RAPID W/FLU A/B _____ IgG/IgM Rapid _____ Other _____
87426 87428 86328

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: _____ Are you worried you may be sick with COVID-19: Y N

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:** _____

****Return to work note needed: Y N**

**** 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.

Covid-Rapid Negative: _____ Covid-Rapid Positive: _____ Flu A _____ Flu B _____

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

Provider Signature: _____ **Date** _____