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 _____

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**

*****VACCINE CLINIC MEDICARE PATIENTS ONLY*** please provide your MEDICARE ID # AND YOUR ADVANTAGE PLAN ID OR SOCIAL SECURITY # IF YOU DO NOT HAVE YOUR MEDICARE CARD.**

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 rapid 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 _____ **Authorized Signature** _____

Credit Card Number _____

Expiration Date _____/_____ **Sec Code** _____ **Charge Amount** _____
_____**$93.00 EACH RAPID test is $155 discounted 40% if no insurance will be filed. Staff will not assist with out of network claim filing) Initial**_____
_____**$175 EACH Lab travel NAAT test. Includes lab fees. NO CLAIM FILING FOR ELECTIVE TRAVEL TEST. Initial** _____

Additional notes. If you are paying for more than one test list 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 _____ ABBOTT _____
U0003 87426 87428 86328 87635

DOCTORS ON CALL COVID-19 Pre-Treatment Screening and Attestation 808-667-7676

Name:_____ **Birth**____/_____/ _____ **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 _____ Headache: Y N_____

Fatigue: Y N _____ Loss of smell: Y N _____Shortness of breath: Y N _____

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

****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 _____ Abbott ID_____

Shannon Richards, FNP-BC , James Barahal, MD, Norman Estin, MD, Corey Dillman, DNP , Maxi Lohrengel-West-PA-C

Provider Signature: _____**Date**_____