DOCTORS ON CALL** MAUI'S URGENT CARE

3350 LOWER HONOAPIILANI, STE 211 LAHAINA, HI 96761*** 22 HANA HWY, KAHULUI HI 96732***3750 WAILEA ALANUI B34, WAILEA 96753

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 FEP/PPO/HMO PLANS. (no quest) HMSA AKAMAI ADVANTAGE, MDX HUMANA, TRICARE,** Secondary plan name and ID enter in below.

**We do not accept out of network MEDICARE ADVANTAGE PLANS or OUT OF STATE MEDICAID.

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______ MDX HAWAII_______TRICARE______________________ 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 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_____

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 Symptoms: _________________________How Long:___________

Have you or someone in your household recently traveled to/from Hawaii in the past 3 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____________

Have you received a Covid vaccine? Y N Date: ___________________ Type: ____________

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 , J Barahal, MD, N Estin, MD, Whitney Hansen, MD, Tia Pilikian, PA-C, Catherine Scott, PA-C

Provider Signature: ____**Date**______________________

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