# TRAVEL TEST PATIENT DEMO FORM

DOCTORS ON CALL** MAUI'S URGENT CARE

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

**PATIENT NAME**: ______________________________________________

First MI Last

**Birthdate**: ______________________ **Male** ________ **Female** _______

**Mailing Address**: ______________________________________________

**ZIP**/City/State ______________________________________________

**Home Phone**: ______________________ **Cell Phone**: ______________________

**Email** ______________________________________________

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**Credit card information is required for all patients during high volume for travel testing**

**Cardholder's Name** ______________________ **Authorized Signature** ______________________

**Credit Card Number** ______________________________

**Expiration Date** ___________/____________ **Sec Code** ________________ **Charge Amount** ________________

_______**$185 Each ABBOTT ID NOW MOLECULAR SARS rapid NAAT/LAMP Covid Test. (Same Day Results)**

**NO CLAIM FILING FOR ELECTIVE TRAVEL TEST.** **Initial** ______

_______**$170 EACH Lab travel PCR OR NAAT Includes CLINICAL LAB HAWAII fees. (Results available in 48-72 hours through Clinical Lab Portal)**

**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:** ______________________________

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***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** ____________________