COVID-19 SCREENING TRIAGE AND TESTING

REVISED 08/02/2021

OFFICE USE ONLY
TEMP: ***Pulse Ox:**

PATIENT CELL PHONE NUMBER: _____

PATIENT NAME: _____ DOB: _____ TODAYS DATE:_____

SCREENING QUESTIONS:

[ ]Yes [ ]No Have you received the COVID-19 Vaccine? If Yes, What Vaccine?_____ Date of last dose:_____

[ ]Yes [ ]No Have you had a confirmed positive COVID-19 test? If Yes, When?_____ was it a [ ]PCR or [ ]Rapid Antigen

[ ]Yes [ ]No Have you been sick with COVID-19 in the past? If Yes, What date did you start symptoms? _____

[ ]Yes [ ]No Have you been in contact with someone known to have COVID-19? If Yes, DATE OF EXPOSURE: _____
Explain the exposure to COVID-19:_____

[ ]Yes [ ]No Have you been told by a public health official that you may have been exposed to COVID-19?

[ ]Yes [ ]No **Do you have any of the following symptoms?** Date Symptoms started: _____ **Check all that apply:**

[ ] Fever
[ ] Cough
[ ] Chills
[ ] Repeated shaking with chills
[ ] Muscle pain or Body aches
[ ] Headache
[ ] Sore throat
[ ] Congestion or Runny Nose
[ ] Nausea or Vomiting
[ ] Diarrhea
[ ] New loss of taste or smell
[ ] *Shortness of breath OR difficulty breathing
[ ] *Persistent pain or pressure in chest
[ ] *Deep Fatigue
[ ] *New Confusion
[ ] *Bluish lips or face

[ ]Yes [ ]No **Do any of these apply to you? If Yes, Check all that apply:**

[ ]Are you 65 years old or older
[ ]Have Immunosuppression
[ ]Have Diabetes
[ ]have Cardiac disease (e.g. coronary artery disease, valvular disease, congestive heart failure)
[ ]Pulmonary disease (e.g. asthma, chronic obstructive pulmonary disease)

COMPLETE THIS SECTION ONLY IF YOU ARE HERE FOR COVID TESTING:

Please read the following and choose a test type below.

Note: No COVID test is 100% accurate, the rapid test gives results in 15 minutes, but if you have had symptoms for more than 5 days, and the result is negative you may need another COVID-19 test and evaluation by a provider to make a clinical diagnosis of COVID-19, or other infection eg. Flu, sinusitis, URI, or other illness.

[ ] INSURANCE: ID #_____CARRIER: _____

[ ] NO Insurance: $70 VISIT CHARGE

Which COVID TEST is right for you?

[ ] RAPID **$20.00 - NOT covered by insurance.**
- IF NOT symptomatic we suggest doing the PCR send out test.
- IF you have insurance we recommend that you do a PCR send out in addition to your Rapid Test with the contracted laboratory. Your insurance will cover the PCR test at no extra cost to you.

[ ] PCR **Test is covered by Insurance and covered by CARES Act for uninsured patients.**
-Test is more sensitive/accurate.
- Result times vary depending on the insurance contracted lab and volume of testing. (Results usually in 2-7 days)

[ ] ANTIBODY **$95.00 IF NOT COVERED BY INSURANCE**. Covered by most insurances. Results in 2-5 days.
-This test is a blood draw done at least 15 days after symptom onset.
-It gives information about whether your body has made SARS Co-V 2 IgM and IgG antibodies.
-A patient without antibodies may not have had COVID-19 and may be at risk of infection.

RAPID COVID TESTING: [ ] I HAVE RECEIVED AND READ THE FACT SHEET FOR THE RAPID TEST:_____
SIGNATURE

PATIENT SIGNATURE: _____

REVIEWED BY
PROVIDER SIGNATURE:

Sunrise Multispecialist Medical Center revised 03/15/19 TODAY'S DATE:_____/_____/_____

Patient Date of Birth: **Patient Name:** **Age:**

PATIENTS CHIEF COMPLAINT: Is this visit related to: [ ]Work Injury [ ]Accident [ ]Motor Vehicle Accident [ ]Other:

What is the Primay reason you are here today?

What is your Preferred Pharmacy: Phone: _____ Fax _____

Name:_____ **Street Address:**_____ **City**_____

REVIEW OF SYSTEMS

Are you experiencing any of the following conditions/symptoms TODAY?

	Mark all that apply			
CONSTITUTIONAL:	[ ]Change in Appetie	[ ]Chills	[ ] Fatige	[ ] Fever
[ ]None of these	[ ] Sweats	[ ]Weight loss		
EYES AND VISION	[ ]Blurred/Double vision	[ ]Contact Lenses	[ ]Eye Discharge	[ ]Eye Pain
[ ]None of these				
EARS/NOSE/THROAT/TEETH	[ ]Dizziness	[ ]Ear pain	[ ]Nasal Congestion	[ ]Nose Discharge
[ ]None of these	[ ]Sneezing	[ ]Sore Throat		
CARDIOVASCULAR / HEART	[ ]Chest Pain or Pressure	[ ] Fainting	[ ]Irregular Heart Beat	
[ ]None of these				
RESPIRATORY / LUNGS	[ ]Congestion	[ ]Cough	[ ]Shortness of Breath	[ ]Wheezing
[ ]None of these				
GASTROINTESTINAL SYSTEM	[ ]Abdominal Pain	[ ]Diarrhea	[ ]Nausea	[ ]Urinary/Bowel Changes
[ ]None of these	[ ]Vomiting			
GENITOURINARY	[ ]Discharge	[ ]Frequent Urination	[ ]Nighttime Urination	[ ]Painful Urination
[ ]None of these				
MUSCULOSKELETAL	[ ]Joint Pain	[ ]Muscle Pain	[ ]Swelling	
[ ]None of these				
SKIN	[ ]Easy Brusing	[ ]Rash/Itching	[ ]Redness	[ ]Skin Sores
[ ]None of these				
NEUROLOGICAL	[ ]Headache	[ ]Light Headedness	[ ]Numbness	[ ]Poor Balance
[ ]None of these	[ ]Tingling	[ ]Weakness		
PSYCHIATRIC	[ ]Anxiety/Nerves	[ ]Depression		
[ ]None of these				
ENDOCRINE SYSTEM	[ ]Diabetes	[ ]Hyper or Hypothyroid	[ ]Heat or Cold Intolerance	
[ ]None of these				
HEMATOLOGIC/BLOOD DISOF	[ ]Frequent Infections	[ ]Swollen Glands		
[ ]None of these				
IMMUNE SYSTEM	[ ]Hay Fever of Allergies	[ ]Food Allergies		
[ ]None of these				
Other: (Please specify)				

PAST MEDICAL HISTORY

Yes	No	List allergies you have:
		Allergies (specify):

List medications you take (Specify):

1
2
3
4
5

Yes	No	Do you have any of the following?
		Cancer (specify type):
		Asthma
		Heart Disease (CAD)
		Stroke (CVA)
		Depression / anxiety
		Diabetes
		Hyperlipidemia (High Cholesterol)
		Hypertension (High Blood Pressure)
		Hypothyroidism
		Other:

Yes	No	Have you had Surgeries or Operations?
		Surgeries (specify):

Yes	No	Does your family have any of the following?		
		Blood Diseases:	❑ Father	❑ Mother
		Cancer or Leukemia:	❑ Father	❑ Mother
		Diabetes:	❑ Father	❑ Mother
		Heart Disease:	❑ Father	❑ Mother
		High Blood Pressure:	❑ Father	❑ Mother
		Strokes:	❑ Father	❑ Mother
		Mental Illnesses:	❑ Father	❑ Mother

Yes	No	Do you use alcohol, drugs or smoke?
		Tobacco Use: How much ? _____ Week.
		Alcohol Use: How much ? _____ Week.
		Drug Use: Describe use & drug: _____.

Yes	No	Are you employed?
		How long Employed?
		Position?

Yes	No	Menstrual History (woman):
		Are you pregnant?
		Last menstrual date?
		Last pap smear date?

Other:

Left or right handed? ❑ Left ❑ Right

Last Tetanus shot date?

Patient Signature: _____ **Date:** _____

MEDICAL ASSISTANT TO COMPLETE:

PATIENTS CHIEF COMPLAINT: _____ LMP: _____

HEIGHT: _____ WEIGHT: _____ TEMP: _____ PULSE: _____ BP: _____ / _____ PO% _____ RESP: _____ Vision: L Cor _____ R Cor _____ L UnCor _____ R UnCor _____

EXAM ROOM # _____ MA NAME/INITIALS: _____

Sunrise Multispecialist Medical Center

867 S. Tustin St., Orange, CA 92866 Tel: 714-771-1420 Fax: 714-771-6918

FRONT OFFICE: FILE THIS FORM ON RIGHT SIDE OF CHART WITH PROGRESS NOTE

FORM TO BE COMPLETED AT EACH OFFICE VISIT

Date of Service: _____

Last Name:_____ First Name:_____ MI:_____ DOB: _____

CHIEF COMPLAINT: What is the primary reason for your visit today? _____

_____

Is this visit related to: [ ]Work Injury [ ]Accident [ ]Motor Vehicle Accident [ ]None of these

URGENT CARE PCP FOLLOW UP INSTRUCTIONS

I understand that I must follow up with my primary care physician for this illness/injury tomorrow and go to an emergency room if this condition worsens.

My Primary Care Physician Name:_____ Phone:_____

_____ _____

Authorized Signature of Patient/Guardian/Accompanying Adult Date

CONSENT FOR TREATMENT

I hereby consent to medical evaluation, testing, and/or treatment provided to me by the staff of this facility which may also include medical and minor surgical treatment or procedures, emergency treatment, and laboratory procedures. I understand that this medical facility may use or disclose Protected Health Information (PHI) necessary to carry out treatment, payment, or healthcare operations. I authorize release of any information concerning me or my child's healthcare, advice, and treatment provided for the purpose of evaluating and administrating claims for insurance benefits. I hereby authorize the facility to administer, prescribe or e-prescribe my prescriptions. For treatment purposes, the facility may request and utilize my medication history from other health care providers or third party pharmacy benefit payers. I acknowledge that if the provider has ordered additional laboratory testing that the collected specimens will be sent to a local laboratory for testing. The facility will forward my payer information to the laboratory and I acknowledge by my signature below that I will be responsible for the charges incurred for these services and I will receive a separate bill from the laboratory. I understand that there may be a portion of the cost of Durable Medical Equipment that is not covered by my insurance and I will be responsible for the balance. I will notify staff of any barrier to effective communication or educational instruction that would prevent the understanding of information about my health status, treatment, or the informed decision making process, such as foreign language, hearing or speech impairment, difficulty with reading or writing, or inability to comprehend verbal instruction.

_____ _____

Authorized Signature of Patient/Guardian/Accompanying Adult Date

NOTICE OF PRIVACY PRACTICES (NPP) ACKNOWLEDGEMENT

A Notice of Privacy Practices (NPP) is provided to all patients. This NPP identifies: 1) How medical information may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our use and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated, and 4) our responsibilities for maintaining your privacy as your medical representative.

I have been offered and have read a copy of the facility's Notice of Privacy Practices, Patient Rights and Responsibilities, and the Patient Payment Policy.

_____ _____

Authorized Signature of Patient/Guardian/Accompanying Adult Date

NOTE: REQUEST FOR MEDICAL RECORD RELEASE CAN BE OBTAINED AT THE FRONT DESK.

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PATIENT INFORMATION

Last Name:_____ First Name:_____ MI:_____ DOB: _____

[ ]Male [ ]Female Age:_____SSN: _____-_____-_____ DL#_____State:_____Exp:_____

Mailing Address: _____City:_____State:_____Zip:_____

Home Phone: _____Cell Phone: _____Work Phone:_____

Email Address: _____

Marital Status: [ ]Single [ ]Divorced [ ]Widow [ ]Married – Spouse Name:_____ Phone:_____

Preferred Language: [ ]English [ ]Spanish [ ]Other: _____ Is this your first visit to our office?: [ ]Yes [ ]No

Race: [ ]Decline to Specify [ ]White [ ]Black [ ]Hispanic [ ]Asian [ ]Other:_____Ethnicity: [ ]Hispanic/Latino [ ]NOT Hispanic/Latino

Employer Name: _____ Occupation: _____

Employer Address:_____City:_____State:_____Zip:_____

Whom may we thank for referring you to us?: [ ]Family/Friend_____ [ ]Physician [ ]Insurance Company [ ]Signs [ ]Other:_____

EMERGENCY CONTACT INFORMATION

Name:_____ Phone:_____ Relationship to Patient:_____

Name:_____ Phone:_____ Relationship to Patient:_____

RESPONSIBLE PARTY/GUARANTOR – (If different from patient - also for patients under 18 years of age)

Last Name:_____ First Name:_____ MI:_____ DOB: _____

Phone: _____ SSN: _____-_____-_____ Relationship to Patient:_____

Mailing Address: _____City:_____State:_____Zip:_____

Other than the Patient/Responsible party, whom may we speak with in regards to any billing questions concerning your Sunrise account? Name or N/A:_____Phone:_____DOB:_____

INSURANCE INFORMATION

[ ] Self Pay / No Insurance [ ] Self Pay / Do Not Bill Insurance

[ ] Card Provided – **Primary Insurance:**

Company:_____ Policy #_____Group# _____

Subscriber Name: _____ DOB:_____ Relationship to Patient:_____

[ ] Card Provided – **Secondary Insurance:**

Company: _____ Policy #_____Group# _____

Subscriber Name: _____ DOB: _____ Relationship to Patient:_____

VERIFICATION OF INFORMATION

I verify that the above information provided is true and correct to the best of my knowledge. I will notify you of any changes in the above information. I hereby authorize the facility to accept assignment of insurance benefits and I understand that I am responsible for coinsurance, copayments, and/or deductibles at the time of service. I understand that if my insurance is a non-contracted plan (out of network), that the facility will courtesy file the claim for services rendered. In the event that I have no insurance coverage, I understand that the fees are due in full at the time of service. I understand that all previous balances owed to the facility will be requested at the time of registration. I understand and agree that, regardless of my insurance status I am ultimately responsible for the full balance of my account for any professional services rendered.

_____ _____

Authorized Signature of Patient/Guardian/Accompanying Adult Date

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FINANCIAL POLICY

We are committed to providing you with the best possible care. In order for us to achieve this goal, we need your assistance and your understanding of our financial policy.

1. Payment for services is due at the time services are rendered unless our staff verifies in advance insurance eligibility and benefits. Although every effort will be made to verify benefits at the time of service, circumstances such as different time zones and/or evenings, weekends, and holidays, when Insurance companies are typically closed for business, will prevent staff in obtaining benefit verification.

2. In the event our staff is not able to verify your Insurance benefits because of the above mentioned circumstances our office will, as a courtesy to you, make an exception to the above policy only after you agree to and sign a pre-authorization payment form. After Insurance verification is obtained on the next business day your credit card will be charged for your patient portion. Co-pays will still be expected on the date services are rendered and are omitted from this exception.

3. Some Insurance companies arbitrarily select certain services they will not cover. You will be responsible for all "non-covered services" per your Insurance Company's policy provisions.

4. Physicians will only handle medical matters. Financial matters shall be directed and handled exclusively by the Billing Department and/or the Office Manager.

5. Sunrise Medical Center welcomes check payments. Please be advised if your check is returned for non-sufficient funds, you authorize your account to be electronically debited or bank drafted for the amount of the check plus any applicable fees. The use of a check for payment is your acknowledgement and acceptance of this policy and its terms and conditions.

6. Returned checks and/or patient balances older than 30 days may be subject to additional collection fees and/or interest charges of 1.5% per month.

7. Sunrise staff will gladly discuss your proposed treatment and answer any questions you may have regarding your Insurance.

*PLEASE NOTE: SPECIMENS THAT ARE SENT TO AN INDEPENDENT OUTSIDE LAB FOR ANALYSIS WILL BE DIRECTLY BILLED TO THE PATIENT BY THE LAB PERFORMING THAT SERVICE AND ARE NOT INCLUDED IN OUR FEES.

We emphasize that as medical care providers, our relationship is with you, not your Insurance Company. While the filing of Insurance claims is a service we extend to our patients, all balances are your responsibility from the date of service rendered. If financial difficulties arise, we encourage you to contact our billing department promptly for assistance in the management of your account.

If you have any questions regarding the above information or any uncertainties about Insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

_____ _____

Authorized Signature of Patient/Guardian/Accompanying Adult Date

DISCLOSURE OF FINANCIAL INTEREST STATEMENT

Pursuant to Business and Professions Code Sections 650.02 (f), 654.2 and Labor Code Section 139.3 which requires a disclosure of financial interest, **WILLIAM H. NUESSE, M.D**., and **MARY-ANN NUESSE, D.O.**, inform their patients that they are the shareholder of **WILLIAM H. NUESSE, M.D. AND MARY-ANN NUESSE, D.O., A MEDICAL CORPORATION**, doing business as **SUNRISE MULTISPECIALIST MEDICAL CENTER.** They hereby disclose that Sunrise Multispecialist Medical Center renders professional medical services to its patients. Also as part of its routine medical practice **SUNRISE MULTISPECIALIST MEDICAL CENTER** provides to its patients Physical Medicine, X-Ray and limited laboratory services. You may be referred for in office Physical Medicine, X-Ray and some laboratory services and related medical procedures, if necessary. If you specify otherwise, you may have Physical Medicine, X-Ray, laboratory and related medical procedures services rendered by any other licensed medical providers of your choice.

I hereby acknowledge that the disclosure of financial interest has been made to me and I may have Physical Medicine, X-Ray, laboratory services and related medical procedures rendered by any other licensed medical providers of my choice.

_____ _____

Authorized Signature of Patient/Guardian/Accompanying Adult Date