PROJECT VISION HAWAI'I
Help for Health

COVID-19 Test Requisition Form
Patient Consent

Date of Service: _____
Location _____
Temp: _____

First Name: _____ Last Name: _____

Date of Birth: _____ Gender: ☐ M ☐ F

Address: _____ City: _____ Zip: _____
Phone: (_____) _____-_____ Email: _____
Social Security #: _____-____-_____ ID #: _____ Type: _____
Insurance Company: _____
Subscriber Name: _____ Member ID #: _____

Where did you sleep last night?
☐ My apartment/home ☐ With family/friend
☐ Outside ☐ Park/encampment ☐ Shelter
☐ Street ☐ Vehicle

Race:
☐ Native Hawaiian ☐ Micronesian ☐ Marshallese ☐ Samoan
☐ Tongan ☐ Other Pacific Islander ☐ Chinese ☐ Filipino ☐ Japanese ☐ Korean ☐ Vietnamese ☐ Black/African American ☐ Alaska Native/Native American ☐ White ☐ Other: _____

Ethnicity:
☐ Hispanic/Latino ☐ Non- Hispanic/Latino

Have **you been vaccinated?** ☐ Yes ☐ No
If yes, please circle type: Johnson & Johnson, Moderna, Pfizer

Have you been exposed to COVID-19 in the last 14 days? ☐ Yes (Z20.828) ☐ Maybe (Z20.822)

Are any of the following symptoms new to you in the last 10 days? ☐ Yes ☐ No

☐ Runny Nose (R09.82) ☐ Fever (R50.9) ☐ Shortness of Breath (R06.02) ☐ Body Aches (R52)
☐ Chest Pain (R07.1) ☐ Headache (R51) ☐ Loss of Taste or Smell (R43.9) ☐ Loss of Appetite (R63)

Do you have any of the following health conditions? ☐ No ☐ Yes *(please circle all that apply)*

Chronic kidney disease; COPD (Chronic Obstructive Pulmonary Disease); Immunocompromised state (weakened immune system) from solid organ transplant, or from blood or bone marrow transplant, immune deficiencies, HIV, use of corticosteroids, or use of other immune weakening medicines (arthritis); Obesity (Body Mass Index [BMI] of 30 or higher); Serious heart conditions, such as heart failure, coronary artery disease, or cardiomyopathies; Sickle Cell Disease; Type 2 Diabetes Mellitus; Asthma (moderate to severe); Cerebrovascular disease (affects blood vessels and blood supply to the brain); Cystic fibrosis; Hypertension or High Blood Pressure; Neurologic conditions, such as dementia; Liver disease; Pregnancy; Pulmonary fibrosis (having damaged or scarred lung tissues); Smoking; Thalassemia (a type of blood disorder); Type 1 Diabetes Mellitus.

Legal consent for treatment:

I authorize, want, and give my consent for this and future COVID-19 testing affiliated with this service provider.

_____I will quarantine until I receive my results, wear a mask, and take all reasonable precautions recommended by my provider.

_____If the test result is found to be positive, I/the patient will isolate for at least 10 days per the State Dept. of Health and the Centers for Disease Control (CDC).

Signature: _____ Date: _____

TO BE COMPLETED BY PROJECT VISION HAWAII STAFF ONLY

Specimen collection (test) performed by PVH Staff (initials): _____

PCR Test performed and sent to lab:
☐ **PCR-CLH** ☐ **PCR-DLS** ☐ **PCR-S&G**

RAPID ANTIGEN Test performed:
☐ **Abbott BinaxNOW** ☐ **CareStart**

Time Collected: _____ **AM/PM**

Time Result Observed: _____ **AM/PM**

Result: ☐ **Negative** ☐ **Positive** ☐ **Inconclusive**

Bill: ☐ **DOH** ☐ **Insurance** ☐ **Uninsured**

PROJECT VISION HAWAI'I
Hele for Health

To be completed by PVH Staff
Medical Record #: _____
Name: _____
Date of Birth: _____

Consent to Payment

I hereby assign to Project Vision Hawai'i all rights privileges and remedies to payment for health care services provide. All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments before services are rendered.

1. **Financial Agreement**
   - I understand payment for costs not covered by the patient's insurance or other third-party payor(s) is the responsibility of the patient or the patient's legal representative.
     - This may include co-pays, deductibles, or costs for evaluations/treatment that are not included as an insurance benefit.
   - I understand if bills are not paid on time, the account may be sent to collections.
     - If this happens, I understand the patient or the patient's legal representative will have to pay for the cost of the collection and/or reasonable fees from the collection.
   - If I have a credit balance or overpayment, it will be applied to any outstanding or unpaid balances on my account(s), before I receive a refund.
   - I understand that once my deductible is met, Medicare pays for 80% of the allowable charges and I am responsible for all remaining balances not covered by Medicare.

2. **Assignment of Insurance Benefits**
   - I hereby assign all benefits, to include major medical benefits to which I am entitled to Project Vision Hawai'i for the care I receive.
   - I hereby authorize and direct my insurance carrier(s), including Medicaid and/or Medicare, private insurance, auto or any other health/medical plan, to issue payment check(s) directly to PROJECT VISION HAWAII, for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any.
   - I understand I am responsible for any amount nor covered by insurance.
   - I agree to cooperate and provide information as needed to establish my eligibility for such benefits.

3. **Authorization to Release Information**

   I hereby authorize PROJECT VISION HAWAII to
   1. Release any information necessary to insurance carriers regarding my treatments and conditions;
   2. Process insurance claims generated during the examination, screening, and/or treatment; and
   3. Allow a photocopy of my signature to be used to process insurance claims for the period lifetime.

   This order will remain in effect until revoked by me in writing.

   I have requested medical services from PROJECT VISION HAWAII on behalf of myself and/or my dependents, and understand by making this request, I become fully financially responsible for any and all charges not covered by insurance if any incurred in the course of this treatment.

   I further understand that fees are due and payable on the date that the services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy or digital copy of this assignment is to be considered as valid as the original.

I have read and understood this form and I accept and agree to follow the conditions contained therein.

Signature: _____ Date: _____

If other* than patient, PRINT your name: _____

Relationship to patient (please circle): Patient/Self, Parent, Guardian, Legal Representative, Other: _____

**If patient is a minor, unable to sign, and/or is incompetent to give consent, relationship of person authorized to give consent (unless otherwise specified by law) must be indicated.*

PVH WITNESS: _____ Date: _____

PROJECT VISION HAWAI'I
Hele for Health

To be completed by PVH Staff
Medical Record #: _____
Name: _____
Date of Birth: _____

Consent to Treatment

1. **Consent to Treatment**
   - I agree to receive treatment from Project Vision Hawai'i mobile facilities as provided or ordered by doctors, nurses, assistants, and other staff employed or contracted by Project Vision Hawai'i.
   - I understand my care may include physical exams, comprehensive visual exams, evaluations, lab tests, procedures, medicines, and other treatment or monitoring, which in my provider's judgement may be helpful to care for my health, facilitate preventative care, or address other medical concerns.

2. **Non-Discrimination Policy**
   I understand Project Vision Hawai'i will treat patients regardless of race, color, national origin, religion, sex, sexual orientation, marital status, veteran's status, age, disability, or housing status.

3. **Consent Effective**
   I understand this consent remains in effect until terminated in writing by me or until legal circumstances change such that a new consent is required.

4. **Changes to Form**
   I understand if I refuse to sign this form or make any changes to this form prior to services being provided it may keep me from getting care and services, except for urgent care/treatment.

I have read and understood this form and I accept and agree to follow the conditions contained therein.

Signature: _____ Date: _____

PRINT name if other* than patient: _____

Relationship to patient (please circle): Patient/Self, Parent, Guardian, Legal Representative, Other: _____

**If patient is a minor, unable to sign, and/or is incompetent to give consent, relationship of person authorized to give consent (unless otherwise specified by law) must be indicated.*

PROJECT VISION HAWAI'I
Hele for Health

To be completed by PVH Staff

Medical Record #: _____

Name: _____

Date of Birth: _____

Privacy Practice Acknowledgement

The Health Insurance Portability and Accountability Act (HIPAA) requires us to give you a notice of our privacy practices and to acknowledge your receipt of the notice.

The Notice of Privacy Practices explains how your health information may be used and or disclosed by us, it explains your rights with regards to your protected health information, as well as our legal responsibilities. You can view the Privacy Practices in one of three manners: we can email you a copy, you can view on our website (www.projectvisionhawaii.org/medical-documentation), or you may request a paper copy.

I have been provided with a copy of the Notice of Privacy Practices in electronic or paper format.

Signature: _____ Date: _____

PRINT name if other* than patient: _____

Relationship to patient (please circle): Patient/Self, Parent, Guardian, Legal Representative, Other: _____

**If patient is a minor, unable to sign, and/or is incompetent to give consent, relationship of person authorized to give consent (unless otherwise specified by law) must be indicated.*

FOR OFFICE USE ONLY:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify):

PVH WITNESS: _____ Date: _____

- representative have the right to access PHI consisting of your vision screening results. Within 30 days after our receipt of your request, you will receive a copy of the completed vision screening results from PVH unless an exception applies. Exceptions include our inability to provide access to the PHI within 30 days, in which case we may extend the response time for an additional 30 days if we provide you with a written statement of the reasons for the delay and the date by which access will be provided. You have the right to access and receive your PHI in an electronic format if it is readily producible in such a format. You also have the right to direct PVH to transmit a copy to another person you designate, provided such request is in writing, signed by you, and clearly identifies the designated person and where to send the copy of your PHI. To request a copy of your PHI:
  1. Ask for a courtesy copy when you visit a PVH mobile screening.
  2. Complete the PVH HIPAA Patient Request Form.
  3. Contact the Privacy Officer at 808.201.3937 or by e-mail at admin@projectvisionhawaii.org.
- **Right to Receive an Accounting of Disclosures** - You have a right to receive a list of certain instances in which PVH disclosed your PHI. This list will not include certain disclosures of PHI, such as (but not limited to) those made based on your written authorization or those made prior to the date on which PVH was required to comply. If you request an accounting of disclosures of PHI that were made for purposes other than screening or health care operations, the list will include disclosures made in the past six years, unless you request a shorter period of disclosures. If you request an accounting of disclosures of PHI that were made for purposes of screening or health care operations, the list will include only those disclosures made in the past three years for which an accounting is required by law, unless you request a shorter period of disclosures.
- **Right to Correct or Update your PHI** - If you believe that your PHI contains a mistake, you may request, in writing, that PVH correct the information. If your request is denied, we will provide an explanation of the reasoning for our denial.

How to Exercise Your Rights

To exercise any of your rights described in this notice, you must send a written request to: Privacy Officer, Project Vision Hawai`i, 1110 Nu'uanu Avenue, Honolulu, HI 96817.

How to Contact Us or File a Complaint

If you have questions or comments regarding the PVH Notice of Privacy Practices, or have a complaint about our use or disclosure of your PHI or our privacy practices, please contact: admin@projectvisionhawaii.org, call us at 808.201.3937 and ask for the Privacy Officer, or send a written request to: HIPAA Privacy Officer, Project Vision Hawai`i, 1110 Nu'uanu Avenue, Honolulu, HI 96817. You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. PVH will not take retaliatory action against you for filing a complaint about our privacy practices.

Revised: October 14, 2017

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

Project Vision Hawai`i's Notice of Privacy Practices

This Notice of Privacy Practices applies to Project Vision Hawai'i and all of its subsidiaries and business units (collectively referred to as "PVH" in this Notice), except to the extent that a subsidiary, division, or business unit of PVH performs acuity screening, flash retina camera screening, autorefractor, and/or tonometer screening, eye exams, and other similar screening.

PVH's Protection of Protected Health Information (PHI)

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), PVH is required by law to maintain the privacy of health information that identifies you, called protected health information (PHI), and to provide you with notice of our legal duties and privacy practices regarding PHI. PVH is committed to the protection of your PHI and will make reasonable efforts to ensure the confidentiality of your PHI, as required by statute and regulation. We take this commitment seriously and will work with you to comply with your right to receive certain information under HIPAA.

PVH's Use and Disclosure of PHI

As permitted under HIPAA, the following categories explain the types of uses and disclosures of PHI that PVH may make. Some of the uses and disclosures described may be limited or restricted by state laws or other legal requirements, for example, the Clinical Laboratory Improvement Amendments of 1988 (CLIA). Please contact our Privacy Officer, using the contact information provided at the end of this notice, for specific information regarding your state.

- **For screening** - PVH may use or disclose PHI for screening referral purposes, including disclosure to physicians and other health care professionals who provide you with health care services and/or are involved in the coordination of your care, such as providing your physician with your vision screening results.
- **For health care operations** - PVH may use or disclose PHI for health care operations purposes. These uses and disclosures are necessary, for example, to evaluate the quality of our vision screening, accuracy of results, accreditation functions, and for PVH's operation and management purposes. PVH may also disclose PHI to other health care providers or health plans that are involved in your care for their health care operations.
- **Individuals involved in your care** - PVH may disclose PHI to a person who is involved in your care, such as a family member or friend. As allowed by federal and state law, we may disclose the PHI of minors to their parents or legal guardians.

- **Business associates** - PVH may disclose PHI to its business associates to perform certain business functions or provide certain business services to PVH. All of our business associates are required to maintain the privacy and confidentiality of your PHI.
- **Disclosure for judicial and administrative proceedings** - Under certain circumstances, PVH may disclose your PHI in the course of a judicial or administrative proceeding, including in response to a court or administrative order, subpoena, discovery request, or other lawful process.
- **Law enforcement** - PVH may disclose PHI for law enforcement purposes, including reporting of certain types of wounds or physical injuries or in response to a court order, warrant, subpoena or summons, or similar process authorized by law. We may also disclose PHI when the information is needed: 1) for identification or location of a suspect, fugitive, material witness or missing person, 2) about a victim of a crime, 3) about an individual who has died, 4) in relation to criminal conduct on PVH premises, or 5) in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.
- **As required by law** - PVH must disclose your PHI if required to do so by federal, state, or local law.
- **Public Health** - PVH may disclose PHI for public health activities. These activities generally include: 1) disclosures to a public health authority to report, prevent or control disease, injury, or disability; 2) disclosures to report births and deaths, or to report child abuse or neglect; 3) disclosures to a person subject to the jurisdiction of the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity, including reporting reactions to medications or problems with products or notifying people of recalls of products they may be using; 4) disclosures to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and 5) disclosures to an employer about an employee to conduct medical surveillance in certain limited circumstances concerning work-place illness or injury.
- **Health oversight activities** - PVH may disclose PHI to a health care oversight agency for activities authorized by law such as audits, civil, administrative, or criminal investigations and proceedings/actions, inspections, licensure/disciplinary actions, or other activities necessary for appropriate oversight of the health care system, government benefit programs, and compliance with regulatory requirements and civil rights laws.
- **Personal Representative** - PVH may disclose PHI to your personal representative, as established under applicable law, or to an administrator associated with your estate.
- **Research** - PVH may use and disclose PHI for research purposes. Limited data or records may be viewed by researchers to identify patients who may qualify for their research project or for other similar purposes, so long as the researchers do not remove or copy any of the PHI.
- **De-identified Information and Limited Data Sets**: PVH may use and disclose health information that has been "de-identified" by removing certain identifiers making it unlikely that you could be identified. PVH also may disclose limited health information, contained in a "limited data set." The limited data set does not contain any information that can directly identify you.

Other Uses and Disclosures of PHI

For purposes not described above, including uses and disclosures of PHI for marketing purposes and disclosures that would constitute a sale of PHI, PVH will ask for patient authorization before using or disclosing PHI. If you signed an authorization form, you may revoke it, in writing, at any time, except to the extent that action has been taken in reliance on the authorization.

Information Breach Notification

PVH is required to provide patient notification if it discovers a breach of unsecured PHI unless there is a demonstration, based on a risk assessment, that there is a low probability that the PHI has been compromised. You will be notified without unreasonable delay and no later than 60 days after discovery of the breach. Such notification will include information about what happened and what can be done to mitigate any harm.

Patient Rights Regarding PHI

Subject to certain exceptions, HIPAA establishes the following patient rights with respect to PHI:

- **Right to Receive a Copy of the PVH Notice of Privacy Practices** - You have a right to receive a copy of the PVH Notice of Privacy Practices at any time by contacting us at admin@projectvisionhawaii.org, calling us at 808.201.3937 and asking for the PVH Privacy Officer, or by sending a written request to: HIPAA Privacy Officer, Project Vision Hawai`i, 1110 Nu'uanu Avenue, Honolulu, HI 96817. This Notice will also be posted on the PVH Internet site at www.projectvisionhawaii.org.
- **Right to Request Limits on Uses and Disclosures of your PHI** - You have the right to request that we limit: 1) how we use and disclose your PHI for treatment and health care operations activities; or 2) our disclosure of PHI to individuals involved in your care. PVH will consider your request, but is not required to agree to it unless the requested restriction involves a disclosure that is not required by law to a health plan for health care operation purposes and not for treatment. If we agree to a restriction on other types of disclosures, we will state the agreed restrictions in writing and will abide by them, except in emergency situations when the disclosure is for purposes of treatment.
- **Right to Request Confidential Communications** - You have the right to request that PVH communicate with you about your PHI at an alternative address or by an alternative means. PVH will accommodate reasonable requests.
- **Right to See and Receive Copies of Your PHI** - You and your personal