SANTA MONICA-MALIBU UNIFIED SCHOOL DISTRICT

Welcome to the SMMUSD Covid-19 Testing Program

Provided by DoctorNow

To ensure your test is processed quickly and accurately, please carefully enter the requested information in the next few pages.

For parents registering students:

1. Enter your child's name as the patient name.

2. Scan the parent/guardian ID in the demographics page.

3. Enter the parent/guardian contact details in the contact page in order to receive the test results.

Testing date and times will be communicated separately by the school district.

It's strongly recommended that you use a mobile device to complete the registration process.

It's important to enter your child's correct date of birth. You will be required to enter this date to access the test results when they are ready.

If you do not have insurance, make sure to select Uninsured and follow the instructions.

Questions regarding SMMUSD's Covid Testing program, contact tbrown@smmusd.org

Issues with registration, contact DoctorNow at info@mydoctornow.net

Get Started

First Name *

Enter First Name

Last Name *

Enter Last Name

Date of Birth *

Select Birth Date

Continue

First Name *

Enter First Name

Please enter a value.

Middle Name

Enter Middle Name

Last Name *

Enter Last Name

Please enter a value.

Date of Birth *

Aug 27, 2021

Gender *

Select Gender

Ethnicity *

Select Ethnicity

Race *

Select Race

Population *

Enter Population

Photo ID (For Minors please Scan Parent/Guardian ID) *

Address Line 1 *

Enter Street Address

Address Line 2

Enter Apt, Suite, etc.

City *

Enter City

State *

Enter State

Country *

Enter Country

Zip Code *

Enter Zip Code

Preferred Contact Method *

Email

Cell Phone *

Enter Cell Phone

Email *

Enter Email

Is this your first time testing for COVID-19? *

Yes | No | Unknown

Are you employed in healthcare? *

Yes | No | Unknown

Are you experiencing any COVID-19 symptoms as defined by CDC? *

Yes | No | Unknown

Have you been hospitalized due to COVID-19? *

Yes | No | Unknown

Have you been admitted to the ICU due to COVID-19? *

Yes | No | Unknown

Are you a resident in a congregate care setting (including nursing homes, residential care for people with intellectual and developmental disabilities, psychiatric treatment facilities, group homes, board and care homes, homeless shelter, foster care or other setting)? *

Yes | No | Unknown

Are you currently pregnant? *

Yes | No | Unknown

If you have health insurance, please enter your policy information below.
If you do not have health insurance, please select "_Uninsured (CARES Act)" in the field titled "Insurance Company." Additionally, in the field titled "Subscriber ID," please enter your Social Security Number, in the field titled "Group #," leave it blank, and in the field titled "Insurance Relationship," please select "Self."

Insurance Rank *

Primary

Insurance Company *

Enter Insurance Company

Subscriber ID

Enter Subscriber ID

Group #

Enter Group #

Insurance Relationship *

Self

Insurance Card (Front)

Insurance Card (Back)

Please read and sign the consent below.

HIPAA & Privacy Requirements & Disclosure

All patients have certain rights to privacy regarding their protected health information. These rights are given to them under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

- Treatment (including direct and indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day health care operations of the practice.

All patients will be informed of, and given the right to review and secure a copy of their Statement of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. We reserve the right to change the terms of this notice from time to time and when contacted will disclose it to our patients

All patients have the right to request restrictions on how their protected health information is used and disclosed to carry the treatment, payment, and health care operations, but that they are not required to agree to these requested restrictions.

All patients may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date they revoke this consent is not affected. Your physician understands the importance of patient confidentiality and is committed to the protection of your personal health information.

All personal identification information is protected and stored on a secure server.

All information given during registration or in a conversation with any of our employees is held in complete confidence. Our employees adhere to the strict standards for patient confidentiality set by the American Medical Association and the Health on the Net Foundation.

We do not share any of your personal information with any of our affiliate or associate sites.

We will not release any personally identifying information to anyone unless mandated by federal or state laws.

BY SIGNING BELOW, YOU AGREE TO RECEIVE LAB RESULTS ELECTRONICALLY VIA TEXT MESSAGE OR EMAIL.

YOU ALSO AGREE TO RELEASE YOUR COVID-19 TEST RESULTS TO SANTA MONICA MALIBU UNIFIED SCHOOL DISTRICT (SMMUSD).

For further information, visit https://www.mydoctornow.net/privacy-policy

If patient is under the age of 18, a parent or guardian must sign this document.

Sign

Please read and sign the consent below.

DoctorNow Informed Consent:

a. I voluntarily consent to DoctorNow providing Covid-19 Testing and related services to me/the patient by its associated physicians, clinicians and other personnel by way of a saliva collection, nasopharyngeal swab, or anterior nares swab as ordered by an authorized medical provider or public health official.

b. I authorize my test results to be disclosed to the SMMUSD representatives as deemed necessary for the enforcement of public health policy and district protocol. Individuals including but not limited to: SMMUSD administrators, site Principal, Vice Principals, and SMMUSD associated health staff. Additionally, results will be disclosed to the county, state, or to any other governmental entity as may be required by law.

c. I acknowledge that a positive test result is an indication that I must self-isolate and/or wear a mask or face covering as directed in an effort to avoid infecting others.

d. I understand DoctorNow is not acting as my medical provider, this testing does not replace treatment by my medical provider, and I assume complete and full responsibility to take appropriate action with regards to my test results. I agree I will seek medical advice, care and treatment from my medical provider if I have questions or concerns, or if my condition worsens.

e. I understand that, as with any medical test, there is the potential for a false positive or false negative COVID-19 test result. I acknowledge my acceptance that the district will not accept repeat tests from samples collected on a different day as evidence of a false positive and that a negative test means that SARS-CoV-2 was not detected but could still be present.

f. I understand that I'm responsible for providing correct and accurate insurance information so the practice can bill my insurance. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with the DoctorNow's Notice of Privacy Practices. I authorize payment of medical benefits to DoctorNow or their designee for services rendered.

If patient is under the age of18, a parent or guardian must sign this document.

Sign

Please read and sign the consent below.

PHYSICIAN-PATIENT ARBITRATION AGREEMENT

Agreement to Arbitrate:

Article 1: It is understood that any dispute as to medical malpractice, that is as to whether my medical services under this contract were necessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration

Article 2: All Claims Must Be Arbitrated: It is the intention of the parties that this agreement shall cover all claims or controversies whether in tort, contract or otherwise, and shall bind all parties whose claims may arise out of or in any way relate to treatment or services provided or not provided by the below identified physician, medical group or association, their partners, associates, associations, corporations, partnerships, employees, agents, clinics, and/or providers (hereinafter collectively referred to as "Physician") to a patient, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children.

Filing by Physician of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim. However, following the assertion of any claim against physician, any fee dispute, whether or not the subject of any existing court action, shall also be resolved by arbitration.

Article 3: Procedures and Applicable Law: A demand for arbitration must be communicated in writing by U.S. mail, postage prepaid, to all parties, describing the claim against the physician, the amount of damage sought, and the names, addresses and telephone number of the patient, and (if applicable) his/her attorney. The parties shall thereafter select a neutral arbitrator who was previously a California superior court judge, to preside over the matter. Both parties shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the arbitrator. Patient shall pursue his/her claims with reasonable diligence, and the arbitration should be governed pursuant to Code of Civil Procedure §§ 1280-1295 and the Federal Arbitration Act (9 U.S.C. §§1 – 4). The parties shall bear their own costs, fees, and expenses, along with a pro rata share of the neutral arbitrator's fees and expenses.

Article 4: Retroactive Effect: The patient intends this agreement to cover all services rendered by physician not only after the date it is signed (including but not limited to emergency treatment), but also before it was signed as well.

Article 5: Revocation: This agreement may be revoked by written notice delivered to physician within 30 days of signature and if not revoked, will govern all medical services received by the patient.

Article 6: Severability Provision: In the event any provision(s) of this agreement is declared void and/or unenforceable, such provision(s) shall deemed severed therefrom the remainder of the agreement enforced in accordance with California law.

If patient is under the age of 18, a parent or guardian must sign this document.

Sign