



DAILY PLANET HEALTH SERVICES
REGISTRATION FOR COVID SCREENING AND TESTING

**BEFORE COMPLETING THIS FORM,
PLEASE PRE-REGISTER AT OUR WEBSITE:
DAILYPLANETVA.ORG**

LAST NAME		FIRST NAME	M. I.
DATE OF BIRTH (MM/DD/YYYY)	SSN	PHONE NUMBER	
ADDRESS	CITY/STATE/ZIP	EMAIL ADDRESS	
EMERGENCY CONTACT NAME	PHONE NUMBER	RELATIONSHIP	
ADDITIONAL INFORMATION:			
RACE(S) - CHECK ALL THAT APPLY: <input type="checkbox"/> Black/African American <input type="checkbox"/> White <input type="checkbox"/> Asian <input type="checkbox"/> Other Pacific Islander <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian			
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic		Primary Language: <input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other	
Sex Assigned at Birth: <input type="checkbox"/> Male <input type="checkbox"/> Female			
Sexual Orientation: <input type="checkbox"/> Heterosexual (straight) <input type="checkbox"/> Lesbian or Gay <input type="checkbox"/> Bisexual <input type="checkbox"/> Something else <input type="checkbox"/> Don't know			
Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender Man/Transgender Male <input type="checkbox"/> Transgender Woman/Transgender Female <input type="checkbox"/> Other			
Are you homeless? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you live in public housing? <input type="checkbox"/> Yes <input type="checkbox"/> No	
		Referred by: _____	
INSURANCE INFORMATION:			
Do you have health insurance? <input type="checkbox"/> No <input type="checkbox"/> Yes		<input type="checkbox"/> Medicaid <input type="checkbox"/> Medicaid MCO <input type="checkbox"/> Medicare	
Relationship to policy holder: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other _____		<input type="checkbox"/> VA Healthcare <input type="checkbox"/> Private <input type="checkbox"/> Other _____ (Please have your insurance card available)	
HOUSEHOLD INCOME: - include all sources, including but not limited to, employment, unemployment benefits, SSI/SSDI, Veterans Benefits, Pension, Retirement, TANF, Child Support, Alimony			
Total Household Income: \$ _____ <input type="checkbox"/> Annually <input type="checkbox"/> Monthly <input type="checkbox"/> Weekly <input type="checkbox"/> Bi-weekly			
Total Number of people in household (including yourself): _____			
I hereby certify that all information provided on this form is true. I understand that this application will be reviewed each visit and that proof of income to qualify for the Sliding Fee Discount Program is required annually, and as income changes. I further understand that, if applicable, I must provide proof of homelessness.			
_____		_____	
Patient Signature		Printed Name	
		Date	



Patient Name: _____

Date of Birth: _____

Daily Planet Health Services

Consent for Treatment, Notice of Privacy Practices Acknowledgement and Financial Responsibility Agreement

Thank you for choosing Daily Planet Health Services (DPHS) as your Health Home. We are committed to providing you high quality of care and service. Please read the information below and sign this form before receiving any DPHS services.

Consent for Treatment

- I authorize medical treatment by the provider, clinical staff and technical employees assigned to my care.
- I authorize my providers to order any ancillary services, such as lab or radiology tests, or any other services or treatments deemed necessary for my care and safety.
- I understand I have the right and the opportunity to discuss alternative plans of treatment with my provider and to ask and have answered to my satisfaction any questions or concerns before treatment is provided.
- In the event that a healthcare worker is exposed to my blood or body fluid in a way which may transmit HIV, Hepatitis B virus, or Hepatitis C virus, I consent to the testing of my blood and/or body fluids for these infections and the reporting of my test results to the health care worker who has been exposed, as required by Virginia law.
- I understand that Daily Planet Health Services uses an electronic prescribing mechanism for electronic transmission of prescriptions and that any medications my provider prescribes for me may be communicated electronically through any local or mail order pharmacy I have designated.
- I understand that Daily Planet Health Services' providers may access prescription information contained in the Virginia Prescription Monitoring program.
- I authorize the release of my prescription history to my Daily Planet Health Services provider from any pharmacy or drug monitoring agency.
- I understand that there are additional consent forms for behavioral health and dental services when registering for those services.

Acknowledgement of HIPAA Notice of Privacy Practices

Our Notice of Privacy Practices (NPP) explains how we may use and disclose health care and billing information about you. As provided in our Notice of Privacy Practices the terms of our notice may change. If we change our notice, you may obtain a revised copy at our website at: www.dailyplanetva.org.

- I have been given an opportunity to read the Notice of Privacy Practices and a copy is available at my request.
- I understand that I may ask questions if I do not understand any information contained in the NPP.
- With my consent, Daily Planet Health Services may:
 - Call my home or other designated location, text or other electronic communication given on the registration forms and leave a detailed message in reference to appointment reminders, insurance, or billing items.
 - Call my home or other designated location, text or other electronic communication, given on the registration forms, and leave a detailed message in reference to my clinical care, including laboratory results or medications.



Patient Name: _____

Date of Birth: _____

I understand that I have the option to authorize Daily Planet Health Services to speak to family members or other individuals about results, findings, and care decisions. I authorize Daily Planet Health Services to communicate with the individuals listed below. I understand that I may revoke or modify this authorization at any time by submitting a written request.

Name	Relationship	Contact Number

Financial Responsibility

I accept that I am financially responsible for all services rendered on my behalf for which a charge may be associated. I accept personal responsibility for the payment of fees, co-pays, co-insurance, deductibles and all other procedures or treatments not covered by my insurance plan. I acknowledge that it is my responsibility to provide DPHS with current insurance information. I authorize DPHS to verify my insurance and submit claims to my insurance carrier. I understand not all services provided at DPHS may be covered by my insurance plan. In the event my insurance plan is not valid or coverage is not active at the time services are rendered, or my provider is not listed as a participating provider by my insurance plan, I will be solely responsible for the amount for the services rendered. I agree to inform the office of any changes in my insurance coverage.

I understand that if my income is below 200% of the Federal Poverty Guidelines, I am eligible to apply to DPHS' Sliding Fee Discount Program, reducing my financial responsibility based on my family size and income. This discount can apply to insurance co-pays, co-insurance and deductibles, as well as self-payments. To qualify, I must provide proof of income. This must be provided within 30 days after registration. After 30 days, with no proof of income, I may be responsible to pay the full cost of service. I agree to notify DPHS of any changes to my income or family status at the time of services.

I understand whether I have insurance or self-pay, I am financially responsible for any costs associated with collection of patient balances. I acknowledge DPHS accepts payment by cash, debt or credit card, check or money order.

Patient Rights and Responsibilities

It is the policy of the Daily Planet Health Services (DPHS) to support and protect the fundamental human, civil, constitutional, and statutory rights of each person receiving its health care services. Furthermore, each patient shall be informed of his/her rights in the language that the client understands. You may request a printed copy at any time or obtain a revised copy at our website at: www.dailyplanetva.org.

By signing below, I acknowledge that I have read, understand, and agree to the above items.

Signature of Patient or Authorized Representative

Printed Name

Date



Sliding Fee Discount Program Eligibility Notice and Requirements

Daily Planet Health Services' mission is to provide accessible quality health services regardless of your ability to pay. A Sliding Fee Discount Schedule is used to determine the fee schedule for services. This Schedule based on the federal poverty income guidelines and is determined by family/household and annual income.

Please bring in within 30 days current copies of one of the following documents as proof of income:

- Current employment paycheck stub--one month
- Copy of all recent year W-2/ or most recent tax return
- Virginia Employment Commission (VEC) record (most recent 3-month period)
- Proof of Public Assistance (e.g., TANF, Food Stamps) NOTICE OF ACTION
- Proof of SSI, SSDI, and/or Social Security payments (e.g., award letter)
- Pension or Retirement income statement
- Copy of unemployment compensation payment
- Copy of Veteran's Benefits determination letter/ income statement
- Copy of child support award/ proof of payment
- Copy of Alimony award/ proof of payment
- Current bank statement with direct deposit information
- Employer Report Letter-Income Statement on employer letterhead

Homelessness documentation from homeless service agency or outreach worker- On agency letterhead, dated within 30 days of appointment.

If homeless and no income, documentation verified by an agency case manager or outreach worker.

If you are unable to pay the required service fees these charges will be billed to your account.

At the time documentation is provided any eligible discount will be applied to previous services retroactively up to 30 days. **After 30 days, with no proof of income**, you may be responsible to pay the **full cost** of service— if you do not have this payment, you may be rescheduled (not seen that day) and asked to bring documentation and payment at the next visit. We appreciate your notifying Daily Planet Health Services of any change in income or dependents at the time of services.

I understand Daily Planet Health Services' proof of income and fee payment policy and **agree to provide the required proof of income information within 30 days of the date shown below** in order to qualify for discounted fees for services.

Patient Name (printed) _____ Patient Signature _____

Date: _____

Legal Representative (printed, if required): _____

Legal Representative Signature: _____



NAME: _____ Birthdate: _____

Job: _____ How many people live in your home? _____

Have you been tested for COVID19 in the past? YES NO

Result: Positive Negative Date of test: _____

Have you been exposed to someone with COVID19? YES NO

At home At Work In the community

Have you received the COVID 19 Vaccine? Date of Dose 1: _____ Date of Dose 2: _____

Are you experiencing any of these symptoms:

- YES NO Shortness of breath? YES NO Chills?
- YES NO Fever? How high? _____ YES NO Fatigue?
- YES NO Cough? YES NO Body Aches?
- YES NO Loss of sense of smell or taste? YES NO Sore Throat?
- YES NO Headaches? YES NO Chest pain?
- YES NO vomiting? YES NO diarrhea?
- YES NO Loss of appetite?

Do you have any of the following:

- YES NO Diabetes?
- YES NO Hypertension?
- YES NO Heart Disease?
- YES NO Asthma?
- YES NO COPD?
- YES NO HIV?
- YES NO Immune system problems? Explain: _____

Please list your medication allergies:

Were you referred by a housing outreach worker? YES NO

If yes, please sign the following consent to share information:

I give Daily Planet Health Services my permission to share my COVID 19 test results with my housing case worker.

Signature _____ Date: _____

*** FOR USE BY MEDICAL STAFF ONLY ***

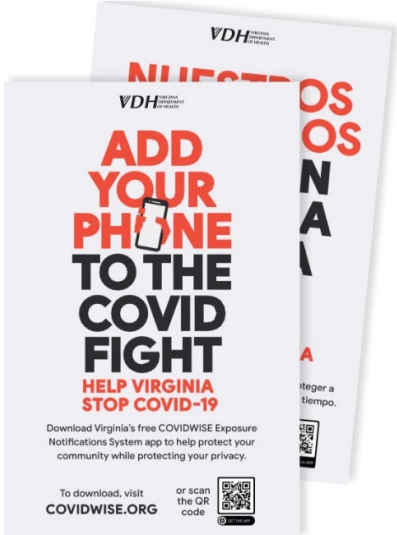
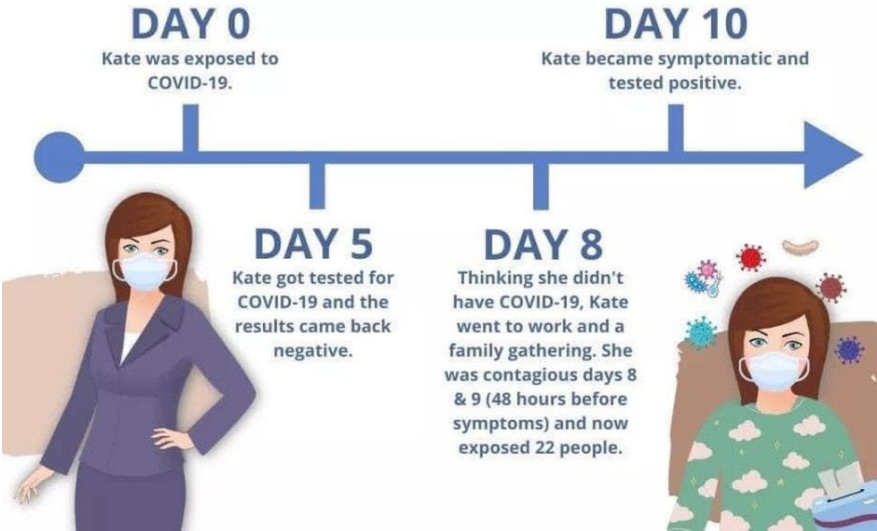
Vitals: POX _____ Temp _____ Pulse _____ Respirations _____ Ag Test _____

Important COVID-19 Information


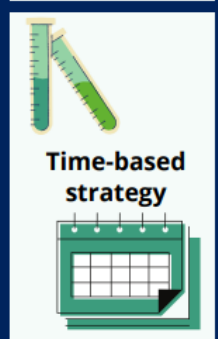
COVID-19 INCUBATION TIMELINE

COVID-19 has up to a 14 day incubation period.

KATE WAS EXPOSED TO COVID-19.



Isolation Guidelines

 <p>Symptom-based strategy</p>	<p>If you had COVID-19 symptoms and were directed to care for yourself at home, you can leave your "sick room" and home after these 3 things have happened:</p> <ul style="list-style-type: none"> ✓ At least 10 days have passed since symptoms first appeared, and ✓ At least 24 hours with no fever without fever-reducing medication, and ✓ Other symptoms have improved.* <p><small>*Note that loss of taste or smell might persist for weeks or months and this should not delay the end of isolation</small></p>
 <p>Time-based strategy</p>	<p>If you tested positive for COVID-19 and never had <u>any</u> symptoms and were directed to care for yourself at home, you can leave your "sick room" and home if:</p> <ul style="list-style-type: none"> ✓ At least 10 days have passed since the date of your first positive COVID-19 diagnostic test, and ✓ You continue to have no symptoms since the test.

You Do Not Need a Re-test to End Isolation

Important COVID-19 Information

Quarantine Guidelines

Close contact includes:

- Being within 6 feet of a person who has COVID-19 for a total of 15 minutes or more over a 24-hour period, or
- Having exposure to respiratory secretions (e.g., being coughed or sneezed on; sharing a drinking glass or utensils; kissing) from a person who has COVID-19, or

- Providing care for a person who has COVID-19, or
- Living with a person who has COVID-19

**A person with COVID-19 is considered to be contagious starting from 2 days before they became sick (or 2 days before test specimen collection if they never had symptoms) until they meet the criteria to discontinue isolation.*

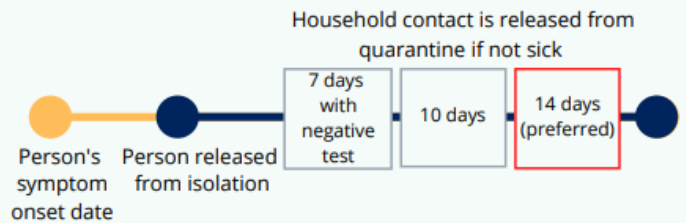
HOUSEHOLD CONTACTS

VDH recommends that you **quarantine (stay home)** while the infected person is home and for **14 days** after the person has been released from isolation (because exposure is considered ongoing within the house)**.



If you are not able to stay home for 14 additional days and do not have symptoms, you may leave home earlier:

- After 10 days without testing; or
- After 7 days with a negative PCR or antigen test performed on or after Day 5.



***If you are able to have **complete separation** from the person in your house with COVID-19 (this means no contact, no time together in the same room, no sharing of any spaces, such as same bathroom or bedroom), then follow timeframe for non-household contact*

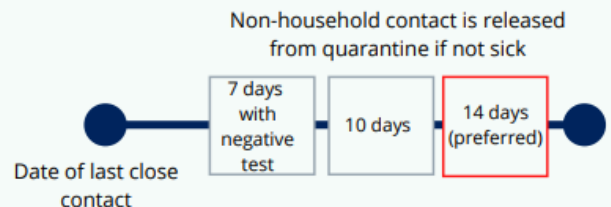
NON-HOUSEHOLD CONTACTS

VDH recommends that you **quarantine (stay home)** for **14 days** after the date of last close contact with the person infected with COVID-19.



If you are not able to stay home for 14 days and do not have symptoms, you may leave home earlier:

- After 10 days without testing; or
- After 7 days with a negative PCR or antigen test performed on or after Day 5.



After your test today, **stay home while you wait for the result**. Your result will come through a text message. If your result is positive, you will also receive an email and/or a phone call. If your test is negative, but you had close contact with a COVID positive person, you should still quarantine for 14 days.

Important Links:

To print a copy of your test results: <https://patient.labcorp.com/>

To contact your provider at Daily Planet Health Services:

https://mycw32.eclinicalweb.com/portal3444/jsp/100mp/login_otp.jsp

For more COVID-19 Information: <https://www.vdh.virginia.gov/coronavirus/#COVID-19-resources>



You've Tested Positive for COVID-19

Isolate yourself from everyone for 10 days from the start of your symptoms

- Stay in one bedroom and one bathroom in your home. If you must share the bathroom, wipe it with bleach after every visit, try to wait 1 hour between users.
- Food, drinks, and other supplies should be left outside the sick room door. Walk away and then the patient can pick up the supplies. Use disposable plates and utensils when possible.
- Have a way for the patient in the sick room to call for help if needed.
- Everyone in the house should wear a mask and follow quarantine guidelines
- You must be fever free – off medication - for at least 24 hours before leaving isolation
- **You do not need a retest to end isolation**

Notify anyone you have been around since 2 days before your symptoms started.

Take Care of Yourself:

Drink plenty of fluids to avoid dehydration.

Take deep breaths every 15 minutes and walk around your isolation space when you feel up to it.

Do not just lay on your back! Spend time on your stomach and on each side to keep your lungs open.

Consider taking a **multivitamin** each day since your appetite may be low.

Symptom	Over-the-Counter Treatments
Fever or headache or body aches	Acetaminophen (Tylenol) or Ibuprofen (Advil or Motrin)
Sore Throat	Acetaminophen or throat spray (chloraseptic), warm salt water gargles, tea and honey
Productive cough (wet cough with mucus)	Expectorant cough medicine with guaifenesin (Robitussin or Mucinex)
Dry Cough	Suppressant cough medicine with dextromethorphan (Delsym)
Both productive and dry cough	Combination cough medicine with guaifenesin and dextromethorphan (Mucinex DM, Robitussin DM)
Stuffy/runny nose	Nasal decongestant with phenylephrine or pseudoephedrine, saline nasal spray, antihistamine

Call for help if:

You have **chest pain**

You are **short of breath** or **lightheaded** when you walk around your room

You have a **swollen leg**

You are monitoring your oxygen and it **stays less than 92%** with deep breath