PalosVerdesMedicalGroup

COVID-19 TESTING – NEW PATIENT

Thank you for choosing Palos Verdes Medical Group. This notice is to inform you of our insurance policies in relation to COVID-19 testing as well as the cash prices for COVID-19 testing.

We are contracted with most PPO insurance plans. If you have an HMO, you must have Optum Healthcare South Bay or Little Company of Mary (also known as HealthCare Partners) as your IPA or medical group to be considered in network with Palos Verdes Medical Group. As a courtesy, we will also bill Kaiser HMO and THIPA-Torrance Hospital IPA for COVID test services only.

If you choose to have antibody testing, please note that we are not billing antibody tests to your insurance unless you have Medicare. **You will need to pay the fee for this test at the time of service.**

If you **are out of network, if these services are not covered by your insurance, or if you do not have insurance coverage at all**, the following are our **cash prices**. These fees will be collected at the drive through COVID-19 testing site:

- COVID-19 Rapid Test (same day results): **$175.00**
- Antibody Test – finger prick (if you choose to have this test): **$150.00**
- Antibody Test with PCR test – additional $50 with test fee
- Optum Care Network Patients: OCN pays for the ABBOTT ID NOW test. If you would like to have the CEPHEID PCR test, the fee will be $100. If test is required for travel, please check with your carrier as to which test is required.

We are required by law to maintain the privacy of Protected Health Information (PHI) however we are required to report all positive COVID-19 test results to the Health Department.

I read, understand & accept the information provided in this Health Insurance Policy and understand I am financially responsible for services rendered.

Last Name: _____ First Name: _____

Sex: M F DOB: _____

Address: _____ City: _____ Zip: _____

Phone: _____ Email: _____

Subscriber Name: _____ Subscriber DOB: _____

Relationship to Patient: _____ Employer: _____

Insurance Company: _____

Claims Address: _____

Subscriber ID#: _____ Group #: _____

Patient's Signature: _____ Date: _____