WAIKIKI HEALTH
MEDICAL & DENTAL • BEHAVIORAL HEALTH • SOCIAL SERVICES

PATIENT REGISTRATION FORM

PLEASE COMPLETE AND PRINT THE FORM PRIOR TO COMING FOR YOUR APPOINTMENT.

PATIENT INFORMATION

First Name: ____ M.I.: ____ Last Name: ____

Preferred Name: ____ Date of Birth: ____

Address: ____ Legal Sex: ____

City: ____ State: ____ Zip: ____ Social Security #: ____

Your answers to the following questions will help us reach you quickly and discreetly with important information.

Home Phone: ____ Cell Phone: ____ Work Phone: ____

Best number to use (check all that apply): ☐ Home ☐ Cell ☐ Work OK to leave voicemail? ☐ Home ☐ Cell ☐ Work

May we text you appointment reminders? ☐ Yes ☐ No Email Address: ____

EMERGENCY CONTACT

Name: ____ Relationship: ____ Phone: ____

DEMOGRAPHICS

This information is for demographic purposes only and will not affect your care.

Preferred Language: ____ ☐ Decline to answer

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Race: ☐ Caucasian ☐ Mexican ☐ Micronesian ☐ African American ☐ Native American
☐ Native Hawaiian ☐ Pacific Islander ☐ Samoan ☐ Chinese ☐ Filipino
☐ Japanese ☐ Korean ☐ Vietnamese ☐ Native Alaskan Other: ____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partner ☐ Unknown

Sexual Orientation: ☐ Straight/Heterosexual ☐ Lesbian/Gay or Homosexual ☐ Bisexual ☐ Don't Know
☐ Choose not to disclose ☐ Something else, please describe: ____

Gender Identity: ☐ Identifies as Male ☐ Identifies as Female ☐ Transgender Male/Female-to-Male
☐ Transgender Female/Male-to-Female ☐ Gender Non-Conforming ☐ Choose not to disclose
☐ Additional gender category/Other, please specify: ____

Assigned Sex at Birth: ☐ Male ☐ Female ☐ Choose not to disclose ☐ Unknown

Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them

INCOME

Family Income: ____ ☐ Monthly ☐ Yearly ☐ Decline to answer

Family Size: ____ Income Level: ____

Agricultural Worker: ☐ Yes (If yes, ☐ seasonal or ☐ migrant) ☐ No ☐ Decline to answer

Homelessness: ☐ Yes ☐ No

If homeless, where are you living: ☐ Shelter ☐ Car ☐ Double Up ☐ Transitional ☐ Street ☐ Other ____

I have been homeless since: ____

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School-based Health Center Patient: ☐ Yes ☐ No ☐ Decline to answer

Public Housing Patient: ☐ Yes ☐ No ☐ Decline to answer

Veteran: ☐ Yes ☐ No

ADDITIONAL INFORMATION

Occupation: ______

Employer: ______ Employer Phone #: ______

Citizenship: ☐ U.S. Citizen ☐ Naturalized Citizen ☐ Permanent Resident ☐ COFA Migrant ☐ Student Visa ☐ Immigrant

Education: ☐ College (degree: ______) ☐ High School ☐ 9th-12th Grade ☐ 8th Grade and below

INSURANCE INFORMATION – *Please present your insurance card(s) to the receptionist.*

Insurance #ID: ______ Secondary Insurance #ID: ______

Insured Name (if different from patient): ______ Phone: ______

Address: ______ Date of Birth: ______

City: ______ State: ______ Zip: ______ Social Security #: ______

Responsible Party – If different from patient, please complete for the individual responsible for payment.

Name: ______ Relationship to patient: ______

Address: ______ Phone: ______

City: ______ State: ______ Zip: ______ Date of Birth: ______

AUTHORIZATION TO USE OR DISCLOSE PHI FOR THE PURPOSE OF INSURANCE REIMBURSEMENTS

Patient Name (print): ______ Date of Birth: ______

MY AUTHORIZATION TO USE OR DISCLOSE PHI FOR THE PURPOSE OF INSURANCE REIMBURSEMENTS, TREATMENT AND ENROLLMENT:

Waikiki Health may use or disclose the following health care information for the purposes of treatment, securing payment for treatment or enrollment of services (*check all that apply*):

☐ I authorize disclosure of all Protected Health Information (PHI)

☐ I authorize disclosure related to today's visit only (choosing this option will require you to re-authorize disclosure during each visit).

☐ I authorize disclosure of health care information for the following date(s) only: ______

☐ I authorize disclosure for ONLY (e.g., X-rays, labs, provider notes) ______

In addition, Waikiki Health may use or disclose information regarding the following conditions (*check all that apply*).

☐ HIV/AIDS ☐ Sexually transmitted diseases ☐ Psychiatric disorders/Mental health ☐ Drug/Alcohol use

HOW DID YOU HEAR ABOUT US?

☐ Advertising ☐ Primary care physician ☐ Specialist physician ☐ Friend ☐ Word of mouth

☐ Patient ☐ Hospital ☐ Insurance company ☐ Other: ______

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PRIVACY

Notices on File: ☐ Privacy Notice, Release of Billing Information and Assignment of Benefits

Consent to Call: ☐ Yes ☐ No (Patient agrees to receive automated phone calls on their mobile phone. Depending on the features your practice offers, phone calls may be about appointments, test results, and more.)

Medication History Authority: ☐ Yes ☐ No (Indicates whether the patient has granted the authority for Waikiki Health to download the patient's medication history automatically from pharmacy benefit managers "PBMs")

CONSENT TO TREATMENT

I understand that Waikiki Health is an integrated clinic with both medical and behavioral health services. I authorize and consent to any diagnostic and/or medical and/or behavioral health treatment under the instructions of the attending provider for which my dependent or I have sought care.

Signature (Patient/Responsible Party/Legal Guardian): ____________ Date: ____________

Print Name: ____________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Waikiki Health keeps a record of health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. Waikiki Health will not disclose your record to others unless you direct us to do so or unless the law authorizes or requires us to do so. You may see your record or get more information about it by contacting the Privacy Officer at (808) 922-4787. Waikiki Health's *Notice of Privacy Practices* describes in detail how your health information may be used and disclosed and how you can access your information.

By my signature below, I acknowledge receipt of the Waikiki Health's Notice of Privacy Practices:

Signature (Patient/Responsible Party/Legal Guardian): ____________ Date: ____________

I certify that everything on this form is true and complete. I understand that falsification may result in the disqualification of services at Waikiki Health for me and my family. I grant Waikiki Health permission to verify this information with income sources listed above.

Signature (Patient/Responsible Party/Legal Guardian): ____________ Date: ____________

ASSIGNMENT OF BENEFITS

PLEASE NOTE, WITHOUT YOUR PERMISSION TO BILL YOUR PRIVATE, STATE, OR GOVERNMENT INSURANCE, YOU ARE OBLIGATED TO PAY FOR ALL COSTS FOR SERVICES PRIOR TO THEM BEING RENDERED.

I understand that I do not have to sign this authorization in order to get health care benefits. However, I do have to sign an authorization form to permit the Waikiki Health to bill my insurance. Once health care information is disclosed, the person or organization that receives it may re-disclose it. I may revoke this authorization in writing. If I did, it would not affect any disclosures already made by Waikiki Health resulting from this authorization. I may not be able to revoke this authorization if its purpose is to obtain insurance. To revoke this authorization, I can write a letter to Waikiki Health; ATTN: Compliance Officer, 277 Ohua Avenue, Honolulu, HI 96815. Waikiki Health reserves the right to modify the Notice of Privacy Practices. The current version is available at www.waikikihealth.org or through the reception staff. You have the right to view the full version of this policy prior to signing this consent.

Signature (Patient/Responsible Party/Legal Guardian): ____________ Date: ____________

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277 Ohua Avenue, Honolulu, Hawaii 96815 • www.waikikihealth.org

HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT 1996 (HIPAA) CONSENT FORM TO ALLOW YOUR HEALTH CARE PROVIDER TO COMMUNICATE ABOUT YOU TO YOUR FAMILY, FRIENDS OR OTHERS INVOLVED IN YOUR CARE.

By signing this form you are granting permission for your provider to communicate with the individuals listed below on any and all health information, medications, tests results, recommended therapy or tests, which he/she deems necessary for them to know while they are involved with your care. Your signature below is voluntary and you can withdraw consent at any time for the following listed individuals to receive your health information. Anyone who inquires about your health status who is not on this list will be referred to contact you. This includes individuals who are calling in to make, confirm or cancel appointments on your behalf.

1. ________________________________ ________________________ ___________________

Print Name Relationship Contact Phone Number

2. ________________________________ ________________________ ___________________

Print Name Relationship Contact Phone Number

3. ________________________________ ________________________ ___________________

Print Name Relationship Contact Phone Number

You can also designate one person with whom we may discuss your billing on your behalf. Please indicate their name here

________________________________ ________________________ ____________________

Print Name Relationship Contact Phone Number

This consent is valid for one year from the date signed unless another date is listed here _______________

________________________________ ________________________ ___________________

Printed Patient Name (or Guardian) Signature Date

________________________________ ________________________ ___________________

Waikiki Health Witness Signature Date

BASIC FINANCIAL ASSISTANCE UNINSURED ATTESTATION

Waikiki Health offers a Fee Scale (SFS) discount from billed charges for services provided to uninsured patients with household income is less than two-hundred-percent of the Federal Poverty Guidelines as outlined in the Department of Health and Human Services, Federally Qualified Health Center (FQHC) program and are Effective January 11, 2019. This discount may not be applicable to care received related to an injury where another individual or entity is responsible for payment.

Payment Expectations: To the best of the patient's ability. Waikiki Health expects a payment or deposit at the time of services rendered. Some days after the appointment, the patient will receive in the mail an itemized statement indicating the discounted balance due with contact information to make payment arrangements. These programs are subject to change or cancellation at any time.

ATTESTATION

I attest as the patient or guarantor for this account on the date of signature, that:

- The patient has no insurance for this service.
- The household annual gross income is less than the amount listed below for my family size.
- The patient has provided proof of income.
- If no proof of income is available at the time of service, patient understands he/she has two weeks to provide proof of income (or by the next office visit) - whichever comes first - otherwise patient will be charged full fee.
- If patient falls on sliding fee B or C, patient must apply for Quest per agency (FQHC) rules.

People in Household	Federal Poverty Rate (HI)*
1	$14,820
2	$20,040
3	$25,260
4	$30,480
5	$35,700
6	$40,920
7	$46,140
8	$51,360

*Rates from ASPE.HHS.ORG (published January 11, 2021)

Patient Signature____ Date___________

Printed Patient Name	

If not patient signing:

Print Name of Signer		Relationship to Patient	

OFFICIAL USE

DOS	
MRN	

Self-Declaration of Income for Sliding Fee Eligibility

Name: ____ DOB: ______________________

Address: ____

I am signing this letter to declare that my financial support comes from (please describe):

____

____

Dollar amount of monthly financial support: ____

I am unable to provide independent verification because: ____

____

____

I understand that this is a temporary verification and by completing, signing, and dating this form that the information I am providing is true and correct. I understand and agree to submit proof of income to Waikiki Health in order to receive continued assistance. I understand that providing false information regarding my income and not submitting proof of income may result in denial of sliding fee eligibility.

Print Name: __________________________________ Date: _________________________

Signature: ____

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Note: all items with asterisk (*) must be completed for the authorization to be valid

Please complete and sign this form to authorize Waikiki Health to release your information that you specify for your stated purpose.

*Patient's Name: ______________________________ Birth Date: ________________

Phone #: ___________________________________

I authorize the request/release of the below Protected Health Information.

To:

*Name of business, organization, OR individual:

____

FAX # *(required if you want your test result faxed)*:

____

From:

WAIKIKI HEALTH

Date(s) of Service: ______________________	Purposes of Use and/or Disclosure:
☐ Entire Medical Record ☐ Medical Bills ✓ Other (Please specify): COVID-19 TEST RESULT	☐ Legal purpose ✓ To release information at my request ☐ Check only if WH requests the authorization for marketing purposes ☐ Check only if WH will be paid for providing health information for marketing purposes ☐ Other (Please specify): _____________________________________

I agree to the release of the following information related to the diagnosis, evaluation or treatment of the following conditions, should it be contained in my medical record:

_______ (initial) Sexually transmitted diseases
_______ (initial) Acquired Immune Deficiency Syndrome (AIDS), HIV, or AIDS-related complex
_______ (initial) Alcohol and/or drug abuse
_______ (initial) Psychiatric disorders/behavioral health/mental health

(Unless I specifically agree, the above information will not be disclosed.)

*Unless otherwise revoked, this authorization will expire on the following date or event: ____. If a date or event is not specified, this authorization will expire one year from my date of signature below.

A reasonable fee may be charged by Waikiki Health for duplication of records. An estimate of those charges will be provided upon request, prior to duplication.

This authorization is voluntary. I understand that Waikiki Health will not condition my treatment, payment, enrollment or eligibility for benefits on the signing of this authorization except as allowed by law.

I understand that I may revoke this authorization at any time by giving written notice of my revocation to Waikiki Health. I understand that the revocation will not apply to any information that is already released or used in reliance on this authorization and there may be other legal restrictions on my ability to revoke this authorization. I understand that the revocation will not apply if the authorization was obtained as a condition of obtaining insurance coverage, when the law provides my insurer with the right to contest a claim under my policy or my policy itself.

I understand that the health information released under this authorization may be re-disclosed by the Recipient without my permission and may no longer be protected under the HIPAA privacy regulations.

I, ________________________________, have had full opportunity to read and consider the contents of this authorization. I understand that, by signing this form, I am confirming my authorization for the use, request, and release of my protected health information, as described in this form.

*Requestor's Signature: ____
Individual or Legally authorized representative

*Date: ____________________

To be completed only if the requestor is not the individual whose information is being released:

*Printed Name: ____

*Relationship to named individual: ____

*Date: ____________________

If the requestor is not the named individual, please provide a court order or other documentation evidencing the authority of the requestor to act on the named individual's behalf.