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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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

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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	

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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: _____

Prevaccination Checklist for COVID-19 Vaccines

For vaccine recipients:

Patient Name _____

Age _____

The following questions will help us determine if there is any reason you should not get the COVID-19 vaccine today. **If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated.** It just means additional questions may be asked. If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No	Don't know
1. Are you feeling sick today?			
2. Have you ever received a dose of COVID-19 vaccine?			
• If yes, which vaccine product did you receive? ☐ Pfizer ☐ Moderna ☐ Another product _____			
3. Have you ever had an allergic reaction to: (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
• A component of the COVID-19 vaccine, including polyethylene glycol (PEG), which is found in some medications, such as laxatives and preparations for colonoscopy procedures			
• Polysorbate			
• A previous dose of COVID-19 vaccine			
4. Have you ever had an allergic reaction to another vaccine (other than COVID-19 vaccine) or an injectable medication? (This would include a severe allergic reaction [e.g., anaphylaxis] that required treatment with epinephrine or EpiPen® or that caused you to go to the hospital. It would also include an allergic reaction that occurred within 4 hours that caused hives, swelling, or respiratory distress, including wheezing.)			
5. Have you ever had a severe allergic reaction (e.g., anaphylaxis) to something other than a component of COVID-19 vaccine, polysorbate, or any vaccine or injectable medication? This would include food, pet, environmental, or oral medication allergies.			
6. Have you received any vaccine in the last 14 days?			
7. Have you ever had a positive test for COVID-19 or has a doctor ever told you that you had COVID-19?			
8. Have you received passive antibody therapy (monoclonal antibodies or convalescent serum) as treatment for COVID-19?			
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or do you take immunosuppressive drugs or therapies?			
10. Do you have a bleeding disorder or are you taking a blood thinner?			
11. Are you pregnant or breastfeeding?			

Form reviewed by _____ **Date** _____

Adapted with appreciation from the Immunization Action Coalition (IAC) screening checklists