Wahiawā Health

Patient Registration: Adult

PATIENT INFORMATION

Legal Last Name	First Name	M.I.	Preferred Name	Date of Birth

***Legal Sex (Please Check One)**
☐ Male ☐ Female

*Sex assigned at birth (male and Female). Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence.

Gender Identity
☐ Male ☐ Female
☐ Transgender male/Female-to-male
☐ Transgender female/male-to-female
☐ Other
☐ Chose not to disclose

Sexual Orientation
☐ Straight (not gay or lesbian)
☐ Lesbian, gay or Homosexual
☐ Bisexual
☐ Something else
☐ Do not Know
☐ Chose not to answer

Home Address	City	State	Zip Code
Mailing Address (If different from Home Address)	**City**	**State**	**Zip Code**

Please compete & indicate your preferred contact method by checking one of the boxes below:

☐ Home Phone ( )
☐ Cell Phone ( )
☐ Day phone ( )
☐ Email Address

SSN: - -

Marital Status:
☐ Single ☐ Married ☐ Separated
☐ Divored ☐ Widowed

Do you need an Interpreter?
☐ Yes ☐ No

Primary or Preferred Language:
☐ English
☐ Other : _____

Ethnicity:
☐ Hispanic / Latino
☐ Not Hispanic / Latino

Race: Please check all that apply:

__ African American/Black __Caucasian __Chamorro __ Chinese __Chuukese __Filipino __Japanese __Korean __Kosraean __Laotian __Marshallese __Native American __Native Hawaiian __Portuguese __Puerto Rican __Samoan __Tongan __Vietnamese __ Other Aisan __Other Pacific Islander __All other (please specify):_____

Family Size: (Includes self, spouse & Children under 18):
_____

Total Family Income:
$_____
☐ Monthly ☐ Annual

Housing Status: ☐ Doubling up ☐ Shelter ☐ Unreported
☐ Not Homeless ☐ Homeless: ☐ Street/Beach ☐ Transitional

Farmer Status:
☐ N/A
☐ Migrant ☐ Seasonal

Active Military or Veteran:
☐ Yes ☐ No

Employer: ☐ Employed ☐ Unemployed ☐ Retired

Occupation:_____

Student: ☐ Full Time ☐ Part Time ☐ Casual

School Name: _____

Wahiawā Health

PATIENT PORTAL / ADVANCE DIRECTIVE

The use of a patient portal is Wahiawā Health Centers latest technology that allows you to schedule and view appointments, request medication refills and see lab results. Access to communicate with your health care team and ask questions regarding your bill and request health records.

Are you enrolled into Patient Portal? ☐ Yes ☐ No

If No, do you need assistance to enroll? ☐ Yes ☐ No

Do you have an Advance Directive? (Form stating how much medical care you want to receive or designating someone to make medical decisions in the event you are not able to respond) : ☐ Yes ☐ No

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:	**Relationship:**	**Contact Information:** ☐ Home ☐ Cell ☐ Work Contact #_____
Emergency Contact Name:	**Relationship:**	**Cotnact Information:** ☐ Home ☐ Cell ☐ Work Contact #_____

PRIMARY MEDICAL INSURANCE INFORMATION

Patient's Relationship to the Insured: (Check one) ☐ Self ☐ Spouse ☐ Parent ☐ Step-Child ☐ Child ☐ Other

Policy Holder Name:	**Date of Bith:**		☐ **Male** ☐ **Female** ☐ **Unknown**	
Plan Name:	**Policy # / Subscriber #**	**Group #:**	**Effective Date:**	**Expiration Date:**
Home Address:		**City:**	**State:**	**Zip Code**
Home Phone:	**Work Phone:**		**Cell Phone:**	

SECONDARY MEDICAL INSURANCE INFORMATION

Patient's Relationship to the Insured: (Check one) ☐ Self ☐ Spouse ☐ Parent ☐ Step-Child ☐ Child ☐ Other

Policy Holder Name:	**Date of Bith:**		☐ **Male** ☐ **Female** ☐ **Unknown**	
Plan Name:	**Policy # / Subscriber #**	**Group #:**	**Effective Date:**	**Expiration Date:**
Home Address:		**City:**	**State:**	**Zip Code**
Home Phone:	**Work Phone:**		**Cell Phone:**	

Wahiawā Health

GUARANTOR INFORMATION

Relationship of Guarantor to patient : ☐ **Self** ☐ **Spouse** ☐ **Parent** ☐ **Other** _____

Legal Last Name:	**First Name**			
Plan Name:	**Policy # / Subscriber #**	**Group #:**	**Effective Date:**	**Expiration Date:**
Home Address:		**City:**	**State:**	**Zip Code**

Home Phone:	**Work Phone:**	**Cell Phone:**

PERMISSION TO DISCLOSE PRIVATE HEALTH INFORMATION

By signing this section below, I give permission to the person(s) listed in the table documented below to receive protected health information including but not limited to medications,appointments and referrals or otherwise listed in the comments section. I may revoke my authorization at any time by submitting a request to change, add, or terminate such permission in writing.

Date of Permission	Name of Individual	Relationship	Telephone #	Comments	Date Permission revoked

I designate this individual with whom WHC can discuss billing information such on my behalf. I may revoke my authorization at any time by submitting a request to change, add, or terminate such permission in writing.Please indicate individuals information below.

Date of Permission	Name of Individual	Relationship	Telephone #	Comments	Date Permission revoked

CONSENT TO CARE FORM

I,_____, the undersigned, hereby give Wahiawa Health Center my consent and permission to obtain historical information, perform physical examinations, order diagnostic tests and give such treatment as the Center physicians deem appropriate for my physical and/or mental health. I understand that this consent is for, but not limited to, obtaining detailed medical and social/psychiatric histories, performance of examinations of mouth, genitals, rectum and ears, repair of minor cuts, tuberculin skin tests, injection of local anesthetics and medications (such as insulin, epinephrine, etc.), injection of immunizations, and all other ordinary medical office procedures.

I understand that for major surgery or other major procedures (such as incision and drainage of abscesses, biopsies, or insertion of such devices as an IUD or Norplant) special explanations will be made to me and special permission obtained from me or from an adult family member if I am physically or mentally impaired from giving such consent. In cases of emergency, I hereby give permission for the rendering of all such medical services deemed necessary to stabilize my condition if I am physically or mentally impaired and an adult family member is not readily available.

I understand that this consent extends to diagnostic tests and services rendered at the Wahiawa Health Center clinic, designated laboratories, X-ray facilities, emergency rooms, offices of specialists, and hospitals by Center physicians as deemed necessary for medical care.

This consent is for the ongoing health care of myself until I withdraw from the Wahiawa Health Center and is given voluntarily. By my signature I hereby certify that I am of legal age (18 years old or older) or am an emancipated minor by the definition of State laws.

I understand that I am not consenting to any experimental procedures nor to any tests solely for the purpose of research or scientific study. My photograph may be used for medical records and for publicizing the Wahiawa Health Center.

I certify that I have read the above (or had read to me) and fully understand the above consent for care. Any inapplicable statements were stricken or any exceptions to the above are indicated below before I signed. Exceptions:

_____

_____

_____

_____

Patient or Legal Guardian Signature/ Date

Wahiawā Health

Informed Consent for Telemedicine/Virtual Communication Services

Telemedicine involves the use of electronic communications to enable health care providers at different locations to assist in the evaluation, diagnosis, management and treatment of a number of health care problems. Providers may include primary care practitioners, specialists, and/or subspecialists.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

By signing this form, I understand the following:

1. The consulting health care provider or specialist will be at a different location from me. A health care provider or other health care professional may be present with me in the room to assist in the consultation.
2. I acknowledge that I have the right to request the following:
   - ☐ Omission of specific details of my/the patients' medical history/physical examination that are personally sensitive.
   - ☐ Asking non-medical personnel to leave the room at time of service if not mandated for safety concerns.
   - ☐ Termination of the service/session at any time.
3. The presenting health care provider or professional health care staff may transmit or share electronically details of my medical history, examinations, x-rays, tests, photographs or other images with the provider who is at a different location.
4. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine that identifies me will be disclosed to researchers or other entities without my consent.
5. I understand that I have the right to withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
6. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas.
7. A record of the consultation will be kept in my medical record.
8. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties.
9. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Wahiawā Health

Please check one of the boxes below which describes your situation:

☐ I have read and fully understand the information provided above regarding telemedicine. I hereby give my informed consent for the use of telemedicine in my health care.

☐ I do not speak or read English and an interpreter has explained this consent to me. I fully understand the terms of this consent and acknowledge that the explanations referred to were made. I hereby give my informed consent for the use of telemedicine in my health care.

Patient Signature: _____ Date: _____

Patient Name Print: _____

Guardian Signature (if applicable): _____ Date: _____

Guardian Name Print: _____

Relationship to Patient: _____

Email: _____

Witness 1: _____ Date: _____

Interpreter (if required): _____ Date: _____

Notice of Privacy Practices

Specially Protected Health Information: Unless otherwise required or permitted under law, disclosure of the following protected health information, outside our health center, requires your specific consent:

- AIDS/HIV information
- Mental health and mental illness records including psychotherapy notes
- Drug addiction and alcoholism (substance abuse) treatment records

Your individual Rights: You have the following rights concerning your health information. A request to exercise any of these rights must be made in writing to the Chief Performance and Compliance Officer and/or the Compliance Specialist.

Right to Alternative Communications: You have the right to request that WHC communicate with you in a certain manner. For example, you may ask that WHC contact you only at work, or a different address than your home address. You may request this during registration.

Right to Inspect and or Copy: You have the right to inspect and obtain copies of your health information. Usually, this includes health and billing records. *It does not include psychotherapy notes, or information we put together to prepare for legal action, and certain laws relating to laboratories.*
To obtain a copy of your health information, please submit a request in writing to the Medical Records Department. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies and services from your request.

We may deny your request to inspect and copy your records in certain very limited circumstances. We will notify you in writing if your request has been denied and explain how you may appeal the decision. In certain limited situations, we will have to deny you access and you will not have the right to appeal that decision.

Right to Amend: If you think that health information in your record is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. You must provide a reason for the amendment. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- We did not create.
- Is not part of the health information kept by our facility.
- Is not part of the information that you are allowed to inspect.
- Is accurate and complete.

Right to Accounting of Disclosures: You have the right to request a list accounting for any disclosures of your health information we have made. This accounting will not include disclosures:

- For treatment, payment, or health care options
- To persons involved in your care or for notification purposes
- Incidental to an otherwise permitted use or disclosure
- To correctional institutions or other law enforcement officials
- As part of a limited data set
- For national security or intelligence purposes
- For any use or disclosure that you specifically authorized or requested

You request must state a time period, which may not be longer than 6 years and not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures within 30 days of your request, or notify you if we are unable to have the list within 30 days and by what date we can have the list; but this date will not exceed 60 days from the date you made the request.

Right to Request Special Restrictions: You have the right to request special restrictions on sharing of your health information. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care. We are not required to agree to your request for restrictions if we are unable to comply or believe it will negatively affect the care we provide for you. In your request, you must tell us what information you want to limit and to whom you want the limits to apply; for example, disclosure of specific information to your spouse.

Right to Copy of This Notice: You have the right to obtain a paper copy of this Notice at any time. Copies of your current Notice are available from our front desk staff.

Changes to this Notice: We reserve the right to change our privacy practices as described in this Notice at any time. Except when required by law, we will write and make available upon request a new Notice before we make any changes in our privacy practices. The privacy practices in the most current Notice will apply to information we already have about you as well as any information we receive in the future. The Notice will contain an effective date.

Contact Us: If you would like further information about your privacy rights, are concerned that your privacy rights have been violate, or disagree with a decision that we made about access to your health information, contact the Chief Compliance Officer at (808) 622-1618 ext 2.

All complaints must be submitted in writing. We will investigate all complaints and will not retaliate against you for filing a complaint with the Office of Civil Rights of the U. S. Department of Health and Human Services. There will be no retaliation for filing a complaint.

Wahiawa Health Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

If you need language assistance, services free of charge, are available to you. Call 808-622-1618 opton 2

I, _____, have read and/or received a copy of the Wahiawa Health Center's Notice of Privacy Practices

_____	_____	_____
Patient or Legal Guardian Signature	Print Name (if not the Patient Signature)	Date

Wahiawā Health

APPOINTMENT KEEPING AGREEMENT

Patient Information

It is important to keep your medical appointment(s) and to be on time. At Wahiawa Health Center, our goal is to provide quality medical care in a timely manner. In our efforts to make your visit more comfortable and to minimize your wait time, we have updated and implemented the following policies and procedures.

A. Check-in Policy:

To ensure access and timeliness of medical care, the front office and medical team will inform you to arrive at your designated check-in time, to allow for registration and screening prior to your scheduled appointment time. You are encouraged to:

1. Call by 3:00 PM on the day prior to your appointment to notify us of any changes; and/or
2. If you may be late for your designated check-in time.

B. Late Arrival Policy

We understand that delays may happen, however, it is important to us to see all patients as timely as possible. Not arriving at your designated check-in time is considered late. Clock times on the WHC Front Desk computers will be used to validate ALL designated check-in times.

If you arrive late for your appointment, you may experience one of the following:

1. You may have to wait to be seen;
2. We will ask you to reschedule your appointment for a later time on the same day, or to another day;
3. We will ask you to reschedule to another provider on the same day if available; or
4. If no open appointments exist, you may wait to see if something becomes available (without any guarantees) to the provider's schedule
5. You may be seen for the remainder of your scheduled appointment time.

C. Cancellation Policy

If you are not able to make your scheduled appointment, please call us at (808) 622-1618 by 3:00 PM on the day prior to your appointment to notify us of any changes or cancellations.

Appointments are in high demand, and your early cancellation will give another person access to timely medical care.

1. If you are not able to speak to someone, please leave a message with your name, phone number, your appointment date/time and request for rescheduling or cancellation reason.
2. If you receive appointment text reminders, you may reply with an "X" to cancel your appointment.

D. No Show Policy:

All patients who miss three (3) appointments dates in a three-month period, will be considered a chronic no show. After the third missed appointment date, you maybe placed on a "Same Day Only" status. You may return to a regular status at the end of the rolling three-month period.

Wahiawa Health Center is committed to providing exceptional care. Your help in keeping your appointments enables us to provide better and timelier care for you and all of our patients.

I have read and consent to these terms.

Print and Sign Patient Name	Print and Sign Parent/Legal Guardian Name	Relationship

Patient Signature (Parent/Legal Guardian if under 18)	Date

Wahiawā Health

Please review and initial boxes below.

Initial	I agree that all charges that are not directly paid by my insurance company will be my responsibility. I hereby authorize Wahiawā Health Center (WHC) to release information to my insurance carrier or organization in order to process claims on my behalf. I authorize payment of medical benefits to WHC for services rendered.
Initial	I certify that the information I have furnished is true and correct to the best of my knowledge. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are Important.
Initial	I authorize WHC to call my residence and/or cellular phone for an appointment reminder. If I am not available, I also authorize WHC to communicate the reminder by leaving a message which will identify the call coming from WHC and will include the date and time of my appointment.
Initial	I have read and understand WHC appointment No Show Policy and understand my responsibility to schedule appointments accordingly and will notify WHC appropriately if I cannot keep my appointment time by 5pm one business day prior to the scheduled appointment time.
initial	I have read and understand the HIPAA / Privacy Policy for The Wahiawā Center for Community Health. I understand that if I or any of my family members do not follow the rules, I may not be able to receive care at this health center.
Initial	I hereby assign my insurance benefits to be paid directly to the healthcare provider.
Initial	I have read and understand the Financial Policy for The Wahiawā Center for Community Health.
Initial	I agree that Wahiawā Center for Community Health may request and use my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes.
Initial	I authorize The Wahiawā Center for Community Health to obtain/have access to my medical/medication history.

FOR OFFICE USE ONLY

Medical Services – Record # _____ | **Collected by:_____ Date:_____** | **Entered by:_____ Date:_____**

PT Status Type: ☐ Scheduled ☐ Inactive ☐ Non-WHC Active

Valid ID: ☐ Scan ID ☐ Update NG pt Picture

Insurance: ☐ Scan Card ☐ Updated Info / Card