

HO'OLA LAHUI HAWAII
 KAUAI COMMUNITY HEALTH CENTER
Medical & Behavioral Health Services

Fill out the information on this form on your computer & then print out and bring it with you to your appointment.

Client Registration Form - Please Complete All Questions

Ho'ola Cares

If you are uninsured, you may apply for a discount according to your family size and income amounts. If you qualify, you would pay a percentage of any billable charges. If you are interested in this discount, please inform us.

CLIENT / PATIENT INFORMATION:

Prefix _____ Last Name: _____ Suffix _____ First Name: _____ MI _____

Previous Name _____ Mailing Address: _____

City: _____ State _____ Zip Code: _____ Residence Address: _____ City: _____ Zip Code: _____

Home Phone No: _____ Cell Phone No. _____ Work Phone No. _____ Ext. _____

Name of Primary Doctor (PCP): _____ Date of Birth: _____ Age _____ Gender: Male Female
 Were you referred? NO YES
 Who Referred You _____ Social Security # _____
 Marital Status: Single Married Widowed Partner Divorced Legally Separated

Student Status (Select One) Not a Student Part Time Student Full Time Student

Employer Name _____

Patient E-mail: _____

Employment Status (Select One)

Full Time Part Time Not Employed
 Self Employed Retired Active Military

EMERGENCY CONTACT INFORMATION:

List Person we may contact in case of emergency (If possible, someone from outside the home.)

Name: _____ Relationship: _____ Phone No.: _____

Family Size: _____

Family Monthly Income: (Please check one box)
 \$0 - \$1,398 \$1,399 - \$1,929 \$1,930 - \$2,096
 \$2,097 - \$2,795 \$2,796 - \$3,494 \$3,495 and above

I do not want to disclose Income Information

Ho'ola Cares Program - (TO BE COMPLETED BY HO'OLA STAFF)

SFS A SFS B SFS C SFS D SFS E SFS F

Self Pay (Please check here if you do not want an insurance claim submitted and wish to pay for entire services rendered at time of service.)

Check If Ok to leave message at your Home Phone Check If Ok to leave message on Cell Phone Check Box If Ok to leave message at Work Phone

HOMELESS: Not Homeless Unknown Homeless Shelter Other On The Street Doubling Up

RACE (SELECT ONE ONLY)		ETHNICITY (SELECT ONE ONLY)	
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Chicano	<input type="checkbox"/> Cuban
<input type="checkbox"/> Asian Indian	<input type="checkbox"/> Chinese	<input type="checkbox"/> Declined to Specify	
<input type="checkbox"/> Black or African American	<input type="checkbox"/> Filipino	<input type="checkbox"/> Hispanic or Latino	
<input type="checkbox"/> Declined to Specify	<input type="checkbox"/> Japanese	<input type="checkbox"/> Mexican	<input type="checkbox"/> Mexican American
<input type="checkbox"/> Guamanian or Chamorro	<input type="checkbox"/> Korean	<input type="checkbox"/> Not Hispanic or Latino	
<input type="checkbox"/> Native Hawaiian	<input type="checkbox"/> Other Pacific Islander	<input type="checkbox"/> Puerto Rican	
<input type="checkbox"/> Samoan	<input type="checkbox"/> Vietnamese	<input type="checkbox"/> White	

WORKER STATUS Migrant Seasonal

ADDITIONAL INFORMATION Check Box if you live in public housing

Who may we talk to about your health?

Name: _____
 Relationship: _____ Phone No.: _____

Primary Language (Please list below)

Are you a Veteran? Yes No

PRIMARY Medical Insurance Information: (A copy of all insurance cards are required) None

Primary Insurance: Subscriber Name: _____
Membership ID # Group # Date of Birth: _____ SSN _____

SECONDARY Medical Insurance Information: (A copy of all insurance cards are required) None

Secondary Insurance: Subscriber Name: _____
Membership ID # Group # Date of Birth: _____ SSN _____

Non-disclosure to Health Insurance:
I do not want my insurance company billed or notified of today's services. I understand that by doing this I am obligated to pay prior to services being rendered to myself or dependent.
Date: _____ **Initial Here:** _____

RESPONSIBLE PARTY INFORMATION

Relationship To Client/Patient: SELF SPOUSE PARENT GUARDIAN
Name: _____ Relation to Patient _____ Contact Phone # _____
Mailing Address: _____ City: _____ Zip Code: _____

PARENT INFO (IF MINOR)

MOTHER NAME	<input type="text"/>	PHONE#	<input type="text"/>	EMAIL	<input type="text"/>
FATHER NAME	<input type="text"/>	PHONE#	<input type="text"/>	EMAIL	<input type="text"/>

Ho'ola Lahui Hawai'i - Authorization and Release Form

I authorize this office to release to the named insurance company any information necessary to secure insurance payment. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand I am responsible for all charges regardless of insurance coverage.
Date _____ **Initial Here:** _____

I authorize and consent to any diagnostic and/or medical/dental treatment under the instruction of the attending physician and/or dentist for which my dependent or I have sought care.
Date _____ **Initial Here:** _____

I grant permission to view prescription history from external sources.
Date _____ **Initial Here:** _____

I give Ho'ola Lahui Hawai'i (Kaua'i Community Health Center) permission to verify the financial and insurance information provided by me to determine eligibility for Ho'ola Lahui Hawai'i (Kaua'i Community Health Center) services. I understand it is my responsibility to keep Ho'ola Lahui Hawai'i (Kaua'i Community Health Center) informed of any changes in my families income and insurance status.
Date _____ **Initial Here:** _____

Client Policy and Procedures: (Please initial)

I have received a copy of the " HIPAA Notice of Privacy Practices ". Date: _____ Initial Here: _____	I have received a copy of the " Client's Rights and Responsibilities and Grievance Procedure ". Date: _____ Initial Here: _____
---	--

The information provided is accurate and complete to the best of my knowledge and is only to be used for my treatment, billing, processing of insurance claims, and/or for qualification for services to which I may be eligible.
Date _____ **Initial Here:** _____

I understand that there is a notification period of 24 hours prior to my appointment or my account will be charged \$25.00 for any appointment(s) not kept. Date: _____ Initial Here: _____	I understand that there is a \$20.00 service charge for any/all returned checks. Date: _____ Initial Here: _____
--	---

Signature (**Patient/Responsible Party/Legal Guardian**) _____ **Date:** _____

If Other signing, Please Print your Name here: _____ **Witness:** _____

Reviewed By Ho'ola Staff: (Name) **Date**