



# Ho'ola Lahui Hawai'i

## Kauai Community Health Center

Medical/Dental & Behavioral Health  
**Client Registration Form**

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

### Sliding Fee Discount

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:

Last Name:  First Name:  MI

Other (Last Name):  First Name:  MI

Mailing Address:  City:  Zip Code:

Residence Address:  City:  Zip Code:

Home Phone No.  Work Phone No.  Cell Phone No.

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

SSN  Date of Birth:  GENDER:  Male  Female

#### 1. RACE:

**SELECT ONE ONLY**

If Other - List Here:

#### 2. ETHNICITY:

**SELECT ONE ONLY**

#### 3. Primary Language:

**SELECT ONE ONLY**

If Other, List Here:

#### 4. Marital Status:

**SELECT ONE ONLY**

#### 5. Veteran Status

Yes

No

Has Family Members That Are Veterans

### EMERGENCY CONTACT INFORMATION:

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

Name:  Relationship:  Phone No.:

### RESPONSIBLE PARTY INFORMATION

- \*\*(If Self, Skip this section and continue to Employer)

**Relationship To Client/Patient:**  SELF  SPOUSE  PARENT  GUARDIAN

Last Name:  First Name:  MI

Mailing Address:  City:  Zip Code:

Residence Address:  City:  Zip Code:

Home Phone No.  Work Phone No.  Cell Phone No.

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

SSN  Date of Birth:  GENDER:  Male  Female

Employer:  Phone No.:  Address:

Family Size:  Family Monthly Income:  City  Zip Code:

HOMELESS:  Not Homeless  Homeless Shelter  On The Street  Doubling Up  Other  If Homeless - List Dates From MM/To YY)

<b>Who may we talk to about your health?</b>	Name: <input type="text"/>	Relationship: <input type="text"/>	Phone No.: <input type="text"/>

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

Primary Insurance:  Membership ID #  Insured Name:

Address:  Date of Birth:  Gender  Male  Female

City:  Zip Code:  SSN

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

Secondary Insurance:  Membership ID #  Insured Name:

Address:  Date of Birth:  Gender  Male  Female

City:  Zip Code:  SSN

**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. 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. 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. 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. Initial Here:

**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.** Initial Here:

**Client Policy and Procedures: (Please initial)**

I have received a copy of the " <a href="#">HIPAA Notice of Privacy Practices</a> ".	<input type="checkbox"/>
I have received a copy of the " <a href="#">Client's Rights and Responsibilities and Grievance Procedure</a> ".	<input type="checkbox"/>
I understand that there is a notification period of 24 hours prior to my appointment or my account will be charged \$40.00 for any appointment(s) not kept.	<input type="checkbox"/>
I understand that there is a \$20.00 service charge for any/all returned checks.	<input type="checkbox"/>

Signature ( <b>Patient/Responsible Party/Legal Guardian</b> ) <input type="text"/>	Date: <input type="text"/>
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**If Other signing, Please Print your Name here:**  Witness:

Reviewed By: <input type="text"/>	Date <input type="text"/>
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