HO'OLA LAHUI HAWAI'I
PHARMACY FITNESS CENTER
KAUA'I COMMUNITY HEALTH CENTER

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KAUA'I COMMUNITY HEALTH CENTER

Medical & Behavioral Health Services

Client Registration Form

Print Form

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

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. _____

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:** _____

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:** _____

Name of PCP: _____ Date of Birth: _____ Age _____ Gender: Marital Status: ☐ Married ☐ Divorced

Were you referred? ☐ NO ☐ YES ☐ Male ☐ Female ☐ Widow ☐ Partner ☐ Single

Who Referred You _____ Social Security # _____ ☐ Transgender ☐ Legally Separated

Employer Name _____ Employment Status **(Select One)** ☐ Full Time ☐ Part Time ☐ Not Employed

☐ Self Employed ☐ Retired ☐ Active Military

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

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

Primary Insurance: _____ Subscriber Name: _____

Membership ID # _____ Group # _____ Date of Birth: _____ SSN _____

Family Monthly Income: **(Please check one box)**		
☐ $0 - $1,223	☐ $1,224 - $1,688	☐ $1,689 - $1,835
☐ $1,836 -$2,447	☐ $2,448 - $3,058	☐ $3,059 and above

Family Size: _____ ☐ I do not want to disclose Income Information

☐ 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.

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: ____

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

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

PARENT INFO (IF MINOR)

MOTHER NAME _____ PHONE# _____ EMAIL _____

FATHER NAME _____ PHONE# _____ EMAIL _____

EMERGENCY CONTACT INFORMATION:
List Person we may contact in case of emergency (If possible, someone from outside the home.

Name: _____ Relationship: _____ Phone No.: _____

☐ 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

RESPONSIBLE PARTY INFORMATION

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

Name: _____ Relation to Patient _____ Contact Phone # _____

Mailing Address: _____ City: _____ Zip Code: _____

RACE (SELECT ONE ONLY)

- ☐ American Indian or Alaska Native
- ☐ Asian ☐ Native Hawaiian ☐ White
- ☐ Black or African American
- ☐ Other Pacific Islander (Guam, Samoa, (Other than Hawaiian)
- ☐ I do not wish to report this
- ☐ I have more than one race

ETHNICITY (SELECT ONE ONLY)

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ I do not wish to report this

Primary Language

_____

Who may we talk to about your health?

Name: _____

Relationship: _____ Phone No.: _____

Are you a Veteran? ☐ Yes ☐ No

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

If Homeless - List Dates From MM/To YY)

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

I have received a copy of the "HIPAA Notice of Privacy Practices". **Initial Here:** ____

I have received a copy of the "Client's Rights and Responsibilities and Grievance Procedure". **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. **Initial Here:** ____

I understand that there is a $20.00 service charge for any/all returned checks. **Initial Here:** ____

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

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

Reviewed By: _____ Date _____

PLEASE SELECT THE CLINIC YOU ARE REGISTERING FOR:

☐ KAPAA MEDICAL CLINIC ☐ WAIMEA MEDICAL CLINIC

Submit by Email