

Please fill in all information requested on this form, as it helps us to better serve you.

Please be assured that all patient information is kept confidential and is only used for Hawai'i Island Community Health Center purposes.

PATIENT INFORMATION

Last Name: _____ MI: _____ First Name: _____ Birthdate: _____

If patient is under 18, Parent/Guardian Name: (1) _____ Relationship to Patient: _____

Parent/Guardian Name (2): _____ Relationship to Patient: _____

Street Address: _____ City: _____ State/Zip: _____

Mailing Address: _____ City: _____ State/Zip: _____

Mobile Phone: _____ Home Phone: _____ Work Phone: _____

Preferred Method of Communication: Text Email Phone Call

Email Address: _____ I do not have email

Legal Sex (reflects what is on ID): Female Male X Nonbinary Unknown

Gender Identity: Female Transgender Female (Male to Female) Decline to answer Don't know
 Male Transgender Male (Female to Male) Choose not to disclose Other: _____

Sex Assigned at Birth: Female Male Not on birth certificate Choose not to disclose Unknown Uncertain

Sexual Orientation (adults only): Straight (not gay/lesbian) Bisexual Unknown Don't know
 Gay Lesbian Something else Choose not to disclose

Marital Status (adults only): Single Legally Separated Domestic Partnership Divorced Unknown
 Married Widowed Significant Other Other: _____

Do you need an interpreter? No Yes Preferred language: _____ Written language: _____

English fluency: Very good Good Not Good Not at all

Form Confidence: Very good Good Not Good Not at all

GENERAL INFORMATION

Race (Please check all boxes that apply.)

- | | | | | | |
|--|---|---------------------------------------|---|---|--|
| <input type="checkbox"/> American Indian/
Alaska Native | <input type="checkbox"/> Asian | <input type="checkbox"/> Asian Indian | <input type="checkbox"/> Black/
African American | <input type="checkbox"/> Chinese | <input type="checkbox"/> Decline to answer |
| <input type="checkbox"/> Filipino | <input type="checkbox"/> Guamanian/
Chamorro | <input type="checkbox"/> Japanese | <input type="checkbox"/> Korean | <input type="checkbox"/> Native Hawaiian | <input type="checkbox"/> Vietnamese |
| <input type="checkbox"/> White | <input type="checkbox"/> Unknown | <input type="checkbox"/> Other: _____ | | <input type="checkbox"/> Other Asian: _____ | |
| <input type="checkbox"/> Other Pacific Islander: | | | | | |
| <input type="checkbox"/> Kosraen | <input type="checkbox"/> Marshallese | <input type="checkbox"/> Micronesian | <input type="checkbox"/> Samoan | <input type="checkbox"/> Tongan | |
-

Ethnicity

- | | | |
|---|---|---|
| <input type="checkbox"/> Cuban | <input type="checkbox"/> Decline to answer | <input type="checkbox"/> Hispanic or Latino/a or Spanish origin, combined |
| <input type="checkbox"/> Hispanic or Latino/a | <input type="checkbox"/> Mexican, Mexican Americano, or Chicano/a | <input type="checkbox"/> Not Hispanic or Latino/a or Spanish origin |
| <input type="checkbox"/> Puerto Rican | <input type="checkbox"/> Unknown | <input type="checkbox"/> Other Hispanic or Latino/a or Spanish origin |
-

Veteran Status

- | | | |
|--|--|--|
| <input type="checkbox"/> No, never served | <input type="checkbox"/> Yes, currently serving/combat veteran | <input type="checkbox"/> Yes, separated |
| <input type="checkbox"/> No, currently serving | <input type="checkbox"/> Yes, separated/combat veteran | <input type="checkbox"/> Decline to answer |

Branch of Service: _____

Homeless Status

- | | | | | |
|--|--|---|----------------------------------|--------------------------------|
| <input type="checkbox"/> I am not homeless | <input type="checkbox"/> Doubling up/Couch surfing | <input type="checkbox"/> Street | <input type="checkbox"/> Unknown | <input type="checkbox"/> Other |
| <input type="checkbox"/> Homeless shelter | <input type="checkbox"/> Transitional housing | <input type="checkbox"/> Permanent supportive housing | | |
-

Public Housing

- No Yes
-

Farm Worker Status (Parent/Guardian or Patient is a farm worker)

- | | | |
|---|--|---|
| <input type="checkbox"/> I am not a farm worker | <input type="checkbox"/> Migratory farm work during last two years | <input type="checkbox"/> Seasonal farm work during last two years |
|---|--|---|

Employment Status

- Employed full-time Retired Student full-time Disabled
- Employed part-time Self-employed Student part-time Not in labor force
- Active military duty Not employed Unknown

Employer: _____ Employer Phone: _____

Occupation: _____ Industry: _____

Are you visually impaired? No Yes

Are you hard-of-hearing? No Yes

Are you an organ donor? No Yes

Do you work in health care? No Yes

Do you reside in a congregate care setting (nursing or group home, dormitory, other)? No Yes

EMERGENCY CONTACTS

Name: _____ Relationship: _____

Phone: _____ Home Mobile Work Birthdate: _____

Street Address/City/State/Zip Code: _____

Preferred Language: _____ Is an interpreter needed for this contact? No Yes

May we speak to this person regarding your care? No Yes Is this person the patient's legal guardian? No Yes

Does this person live in the same household? No Yes May we notify this person in case of an emergency? No Yes

Alternate Emergency Contact Name: _____ Relationship: _____

Phone: _____ Home Mobile Work Birthdate: _____

Street Address/City/State/Zip Code: _____

Preferred Language: _____ Is an interpreter needed for this contact? No Yes

May we speak to this person regarding your care? No Yes Is this person the patient's legal guardian? No Yes

Does this person live in the same household? No Yes May we notify this person in case of an emergency? No Yes

FINANCIAL INFORMATION

Your responses to the financial questions below help us receive grant funding so we can continue providing health care services to our community. This information may help you qualify for additional benefits, such as Sliding Fee Scale, or discounts on medication and other services. If you would like more information, please check this box: and one of our eligibility specialists will reach out to you.

Family Size: _____

Monthly Gross Family Income:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> No income | <input type="checkbox"/> \$100–499 | <input type="checkbox"/> \$500–999 | <input type="checkbox"/> \$1,000–1,499 |
| <input type="checkbox"/> \$1,500–1,999 | <input type="checkbox"/> \$2,000–2,499 | <input type="checkbox"/> \$2,500–2,999 | <input type="checkbox"/> \$3,000–3,499 |
| <input type="checkbox"/> \$3,500–3,999 | <input type="checkbox"/> \$4,000–4,499 | <input type="checkbox"/> \$4,500–4,999 | <input type="checkbox"/> Other (specify): _____ |

MEDICAL INSURANCE/GUARANTOR INFORMATION

Patient's relationship to Subscriber/Member: Self Spouse Child Other: _____

Health Insurance Company: _____ Policy #: _____ Group #: _____

Subscriber's Employer: _____ Policy #: _____ Group #: _____

Subscriber Name (Last, First, MI): _____ Male Female Date of Birth: _____

Subscriber Mailing Address: _____ City/State/Zip: _____

SECONDARY MEDICAL INSURANCE/GUARANTOR INFORMATION

Patient's relationship to Subscriber/Member: Self Spouse Child Other: _____

Health Insurance Company: _____ Policy #: _____ Group #: _____

Subscriber's Employer: _____ Policy #: _____ Group #: _____

Subscriber Name (Last, First, MI): _____ Male Female Date of Birth: _____

Subscriber Mailing Address: _____ City/State/Zip: _____

PERMISSION AND RELEASE

Please review the following statements, and indicate your agreement with them by signing below.

- I do not have Kaiser. (Hawai'i Island Community Health Center does not participate with Kaiser.)
- If we do not participate with your insurance provider (such as Kaiser), you are responsible for full payment.
- I have accurately disclosed all information about my finances (money) and insurance.
- I am responsible to notify Hawai'i Island Community Health Center about any changes in finances or insurance coverage.
- I authorize Hawai'i Island Community Health Center, its providers and staff, to provide insurance companies with any information needed to receive payment for my visits. My signature below may be used on all insurance forms.
- I give permission to Hawai'i Island Community Health Center to share my information among all of its groups (medical, dental, behavioral health, health education, case management) so that my family and I can receive the best care.
- I authorize Hawai'i Island Community Health Center to send appointment reminders to me via voice call, text messages, and/or email.
- Today's co-pay or charges are a minimum payment for your visit. Any additional charges that are not covered by your insurance will be billed to you. **I understand that I am responsible for the balance due after insurance and/or the sliding fee scale have been applied.**
- **I understand that Hawai'i Island Community Health Center does not accept Worker's Compensation and No-Fault (MVA) insurance. If either of these is applicable to my situation, I will disclose this to Hawai'i Island Community Health Center so that I can be referred to a doctor in the community who can see me.**
- **All of the information that I am presenting is correct and complete.**

By signing here, I acknowledge my agreement with the above statements, permissions, and releases:

Signature (Patient/Person Responsible/Legal Guardian): _____

Print Name: _____ **Date:** _____

Witness Signature (if other than the Patient has signed above): _____

Print Witness Name: _____ **Date:** _____

PATIENT RIGHTS

- To be treated with dignity and respect.
- To know the name and professional status of people serving you.
- To confidentiality of your medical records.
- To receive complete and accurate information about your health-related concerns.
- To know the effectiveness and possible side effects of all forms of treatment.
- To receive verbal education, counseling, and written materials related to your medical condition and/or treatment.
- To accept or refuse any care or treatment.
- To select and/or change your health care provider.
- To review your medical records with the clinical staff provider.
- To receive information about services and related costs.

PATIENT RESPONSIBILITIES

- To provide medical history to the clinical staff including medical records and a list of current medications.
- To provide Hawai'i Island Community Health Center with proof of income, as required by the state of Hawaii (pertains to Sliding Fee Schedule applicants only).
- To notify HICHC of any changes in insurance, income status, addresses, and phone numbers.
- To treat other patients and HICHC staff with respect. Swearing, threatening or aggressive behavior could result in immediate discharge from the clinic.
- To notify HICHC if you will be late or unable to make your appointment. You may be rescheduled if you are 15+ minutes late.
- To contact your insurer if you have questions about your coverage. Your medical, dental, and prescription coverage is a policy between you and your insurer.
- To pay any amount due, or for an item that may not be covered, on the date of service.
- To follow the treatment plan made by your physician, when accepting care.
- To be responsible for your medications. Request for refills will require at least 48 hours notice or an office visit, as required by your physicians.
- To be present in the clinic during appointments for any minor children you are legally responsible for.
- To attend to your child's or children's behavior while in the waiting room or exam room, so as not to disturb others. Please provide adult supervision for your child/ren during your appointment, or reschedule your appointment if this cannot be arranged. HICHC staff will not be responsible for minor children.
- To refrain from bringing your pets into the health center except for service dogs.

By signing below, I acknowledge that I understand and agree to the foregoing Patient Rights and Responsibilities.

Signature of Patient (or Parent/Guardian, if Patient is a Minor): _____

Print Name: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Hawai'i Island Community Health Center (HICHC) keeps a record of health care services we provide you. You may ask to see and receive a copy of that record. You may also ask to correct that record.

HICHC 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 us.

HICHC'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 Hawai'i Island Community Health Center Notice of Privacy Practices.

PATIENT ACKNOWLEDGEMENT

Signature of Patient (or Authorized Representative)	Date
Print Name of Authorized Representative	Relationship to Patient

I have read the Patient's Rights & Responsibilities: Yes No Please initial: _____

This form will be retained in your medical record.

CONSENT TO LEAVE MESSAGES

I understand that my health care information is protected. I understand that if I would like messages to be left for me when I'm not immediately available, I need to expressly give permission to HICHC to leave detailed messages containing specifics related to my care, referrals, or appointments.

I prefer **not** to receive voice messages related to my care.

Please note that if you opt not to receive messages, we ask that you pay close attention to calls received, and return any calls from the health center to avoid delays in your care.

I give my permission for voice messages to be left for me at the following number: _____

If you'd like a digital copy of HICHC's Notice of Privacy Practices, you can access it by using this link: https://bit.ly/HICHC_Privacy or by scanning this QR code with your smartphone:





NO-SHOW POLICY (EFFECTIVE 2/5/2018)

A "no-show" is defined as a patient who has a scheduled appointment and fails to appear without calling the health center to cancel or reschedule their appointment at least 24 hours prior to their appointment time.

- If a patient is unable to make their scheduled appointment, they are to call at least 24 hours before their appointment to cancel or reschedule.
- Patients will have the opportunity to reschedule up to three (3) missed appointments.
- Repeated no-shows on a consistent basis during a six-month period may result in a patient's scheduled appointment being double-booked and potentially resulting in longer wait times for a period of six months.

PATIENT ACKNOWLEDGEMENT

Signature of Patient (or Parent/Guardian, if Patient is a minor): _____

Print Name: _____ Date: _____