Hawai'i Island Community Health Center

Today's Date: _____

PATIENT REGISTRATION

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: (adults only)
☐ 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.)

- ☐ American Indian/ Alaska Native
- ☐ Asian
- ☐ Asian Indian
- ☐ Black/ African American
- ☐ Chinese
- ☐ Decline to answer
- ☐ Filipino
- ☐ Guamanian/ Chamorro
- ☐ Japanese
- ☐ Korean
- ☐ Native Hawaiian
- ☐ Vietnamese
- ☐ White
- ☐ Unknown
- ☐ Other: _____
- ☐ Other Asian: _____
- ☐ Other Pacific Islander:
  - ☐ Kosraen
  - ☐ Marshallese
  - ☐ Micronesian
  - ☐ Samoan
  - ☐ Tongan

Ethnicity

- ☐ Cuban
- ☐ Decline to answer
- ☐ Hispanic or Latino/a or Spanish origin, combined
- ☐ Hispanic or Latino/a
- ☐ Mexican, Mexican Americano, or Chicano/a
- ☐ Not Hispanic or Latino/a or Spanish origin
- ☐ Puerto Rican
- ☐ Unknown
- ☐ Other Hispanic or Latino/a or Spanish origin

Veteran Status

- ☐ No, never served
- ☐ Yes, currently serving/combat veteran
- ☐ Yes, separated
- ☐ No, currently serving
- ☐ Yes, separated/combat veteran
- ☐ Decline to answer

Branch of Service: _____

Homeless Status

- ☐ I am not homeless
- ☐ Doubling up/Couch surfing
- ☐ Street
- ☐ Unknown
- ☐ Other
- ☐ Homeless shelter
- ☐ Transitional housing
- ☐ Permanent supportive housing

Public Housing

- ☐ No
- ☐ Yes

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

- ☐ I am not a farm worker
- ☐ Migratory farm work during last two years
- ☐ 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:

☐ No income ☐ $100–499 ☐ $500–999 ☐ $1,000–1,499

☐ $1,500–1,999 ☐ $2,000–2,499 ☐ $2,500–2,999 ☐ $3,000–3,499

☐ $3,500–3,999 ☐ $4,000–4,499 ☐ $4,500–4,999 ☐ 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: _____

Hawai'i Island Community Health Center

ACKNOWLEDGEMENT OF RECEIPT: NOTICE OF PRIVACY PRACTICES

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: _____

MINOR (CHILD) POWER OF ATTORNEY

Hawai'i Island Community Health Center (HICHC) requests that you complete the form on the reverse to allow another adult to bring your child (or children) to the clinic for an appointment **in the event that you are unable to do so**.

This is a state requirement that a minor cannot be seen or treated without the parent or a legal guardian present to consent except for some specific circumstances.

HICHC will require this document to be **signed by you and notarized to authorize another adult (18+ years) to bring your child, view medical records, and make any type of health care decision on behalf of your child (children).**

This document will be kept in our files and will be used to verify the identification of the adult who brings your child or children to the health center. If there is more than one person you would like to designate, please provide their names and relationships to your child (children).

We appreciate your cooperation and assistance with this requirement. We have a staff member who can notarize the document at no cost to you, so please let us know if you would like to request this service.

Hawai'i Island Community Health Center

MINOR (CHILD) POWER OF ATTORNEY

PLEASE PRINT CLEARLY

Please indicate your relationship to Patient: ☐ Mother ☐ Father ☐ Parents ☐ Legal Guardian(s)

I (or we), (print name(s)): _____

living at home address(es): _____

give rights to make parental or guardian decisions on behalf of the Minor(s) named below to the person(s) listed below as Attorney(s)-in-Fact, and grant said Attorney(s)-in-Fact powers to view medical/dental records and make any type of health care decision for my (our) child/ren.

ATTORNEY(S)-IN-FACT (List adult(s), age 18+, to whom you give the above rights on behalf of your child/ren)

Name: _____ Birthdate: _____ Relationship to Child: _____

Name: _____ Birthdate: _____ Relationship to Child: _____

Name: _____ Birthdate: _____ Relationship to Child: _____

MINOR CHILD/REN (List those who are under 18 years of age)

Name: _____ Birthdate: _____

Name: _____ Birthdate: _____

Name: _____ Birthdate: _____

Parent Signature(s): _____ **Date:** _____

Witness 1: _____ **Date:** _____

Witness 2: _____ **Date:** _____

Acceptance by Attorney-in-Fact: The undersigned Attorney-in-Fact acknowledges and executes this Power of Attorney, and by such execution does hereby affirm that I: (a) accept the appointment; (b) understand the duties under the Power of Attorney and under the law.

Attorney(s)-in-Fact: _____

STATE OF HAWAII

County of _____

On this _____ day of _____ 20____, before me personally appeared _____ to me known to be the person (or persons) described in and who executed the foregoing instrument, and acknowledged that he/she/they executed the same as his/her/their free act and deed.

Witness my hand and seal.

Notary Public Signature: _____

Notary Name: _____

Commission #/Exp Date: _____

Document Description: _____

Document Date: _____ # of Pages: _____