Aloha and welcome to the Hui Mālama Ola Nā ‘Ōiwi Family Medicine Clinic. Mahalo nui for your interest in becoming one of our patients. Hui Mālama Ola Nā ‘Ōiwi is a 501(c)(3) nonprofit organization dedicated to improving the health & wellness of Hawai‘i island. Services are offered island-wide and open to the community.

We take a comprehensive approach to help you and your ‘ohana (family) reach your wellness goals, and stay as healthy as possible. Our care team includes kauka (doctors), a licensed clinical social worker, a registered dietitian, and certified medical assistants. In the near future, we anticipate also having students in medicine, nursing, clinical pharmacy, and behavioral health sciences. All patients of our clinic should expect to be seen by various team members including students, at times. We appreciate your patience as we re-establish our clinic in Hilo on Hawai‘i island, and would like to assure you that you will be getting very comprehensive and detail-oriented care.

As the Native Hawaiian Health Care System serving Hawai‘i island, we are committed to providing the best care possible to our community as a whole. Please complete the patient registration documents, including your health history, so that we can assess your health care needs. We will review your application and if you are accepted as a patient, we will request your medical records from your previous provider/s within the last seven years and contact you to schedule your initial appointment. We will try our best to communicate any delays to you should there be any concerns or issues.

Again, mahalo nui loa for your interest in becoming a patient with Hui Mālama Ola Nā ‘Ōiwi Family Medicine Clinic. We believe you will enjoy being a patient and look forward to being your Medical Care team.

**PRIMARY CARE PROVIDERS**
Gaku Yamaguchi, MD  
Susan Cauley, MD  
K.C. Kapa‘akea Pua‘a, MD

**BEHAVIORAL HEALTH**
Donna Dennerlein, LCSW

**NUTRITION AND HEALTH EDUCATION**
Stacy Haumea, DBH, RDN, CDE
**HUI MĀLAMA OLA NĀ ʻŌIWI**
Hawai‘i Island Health Care System
Health & Program Services

**CLIENT/PATIENT REGISTRATION FORM**

Services interested in: □ Medical/Behavioral Health Services  □ Traditional Hawaiian Health  □ Exercise  □ Nutrition
□ Diabetes Program  □ Specialty Transportation  □ Healthy Hapai Program  □ Hypertension  □ Cancer Support Group

If interested in Medical/Behavioral Health Services fill out entire form. All other services fill out only the shaded areas

<table>
<thead>
<tr>
<th><strong>Patient Legal Last Name</strong></th>
<th><strong>Suffix</strong></th>
<th><strong>Patient First Name &amp; Middle Initial</strong></th>
<th><strong>Nickname</strong></th>
</tr>
</thead>
</table>

<table>
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<tr>
<th><strong>Residence Address</strong></th>
<th><strong>City/Town</strong></th>
<th><strong>Zip code</strong></th>
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</table>

<table>
<thead>
<tr>
<th><strong>Mailing/Other Address</strong></th>
<th><strong>City/Town</strong></th>
<th><strong>Zip Code</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Home Phone #</strong></th>
<th><strong>Cell Phone #</strong></th>
<th><strong>Work Phone #</strong></th>
<th><strong>Email</strong></th>
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<tr>
<th><strong>Date of Birth</strong></th>
<th><strong>Age</strong></th>
<th><strong>Social Security Number</strong></th>
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</table>

<table>
<thead>
<tr>
<th><strong>Name of Primary Care Provider</strong></th>
<th><strong>Were you referred?</strong></th>
<th><strong>Yes</strong></th>
<th><strong>No</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Who referred you:</strong></td>
<td><strong>____________________</strong></td>
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<td></td>
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<tr>
<th><strong>Marital Status</strong></th>
<th><strong>Gender:</strong></th>
<th><strong>Male</strong></th>
<th><strong>Female</strong></th>
<th><strong>Transgender Male/Female</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Single</td>
<td>□ Female</td>
<td>□ Transgender Male/Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Married</td>
<td>□ Other</td>
<td>□ Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>□ Legally Separated</td>
<td>□ Transgender Male/Female</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Sexual Orientation:</strong></th>
<th><strong>Straight</strong></th>
<th><strong>Gay/Lesbian</strong></th>
<th><strong>Bisexual</strong></th>
<th><strong>Something else</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>□ Don’t Know</td>
<td>□ Choose not to disclose</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**RESPONSIBLE PARTY INFORMATION**

**RELATIONSHIP TO PATIENT:** □ SELF  □ SPOUSE  □ PARENT  □ GUARDIAN

<table>
<thead>
<tr>
<th><strong>Name:</strong></th>
<th><strong>Relationship to Patient</strong></th>
<th><strong>Contact #</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Mailing address:</strong></th>
<th><strong>City/State:</strong></th>
<th><strong>Zip code:</strong></th>
</tr>
</thead>
</table>

**PRIMARY INSURANCE INFORMATION:** □ None  □ Medical

<table>
<thead>
<tr>
<th><strong>Primary Insurance:</strong></th>
<th><strong>Membership ID#</strong></th>
<th><strong>Group#</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Subscriber Name:</strong></th>
<th><strong>Date of Birth:</strong></th>
<th><strong>SSN#</strong></th>
</tr>
</thead>
</table>

**SECONDARY INSURANCE INFORMATION:** □ None  □ Medical

<table>
<thead>
<tr>
<th><strong>Secondary Insurance</strong></th>
<th><strong>Membership ID#</strong></th>
<th><strong>Group#</strong></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th><strong>Subscriber Name:</strong></th>
<th><strong>Date of Birth</strong></th>
<th><strong>Group#</strong></th>
</tr>
</thead>
</table>

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:** ______

<table>
<thead>
<tr>
<th><strong>Are you pregnant?</strong></th>
<th><strong>Yes</strong></th>
<th><strong>No</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Are you a parent of a child under 3?</strong></td>
<td><strong>Yes</strong></td>
<td><strong>No</strong></td>
</tr>
<tr>
<td><strong>Are you diagnosed with any of the following?</strong></td>
<td><strong>Diabetes</strong></td>
<td><strong>Hypertension</strong></td>
</tr>
</tbody>
</table>

*If yes, have you received prenat care in your first trimester of pregnancy?* □ Yes □ No

*If yes, has your child received the 19 recommended immunization shots?* □ Yes □ No □ I don’t know

**HOUSEHOLD INFORMATION**

<table>
<thead>
<tr>
<th><strong>Income</strong></th>
<th><strong>$ ____________</strong></th>
<th><strong>Monthly</strong></th>
<th><strong>Annual</strong></th>
<th><strong>Family Size ______</strong></th>
<th><strong>I don’t want to disclose income information</strong></th>
</tr>
</thead>
</table>
### Patient Registration Form

**Homeless**
- [ ] Not Homeless
- [ ] Homeless Shelter
- [ ] Transitional
- [ ] Doubling Up

- [ ] Street
- [ ] Other ______

If homeless, for how long: ____________

- [ ] Homeless Shelter
- [ ] Other ______

**Primary Language**
- [ ] English
- [ ] Hawaiian
- [ ] Other ______

**Are you Hawaiian?**
- [ ] Yes
- [ ] No

**Race (check all that apply)**
- [ ] Native Hawaiian
- [ ] Black
- [ ] Asian
- [ ] American Indian or Alaska Native
- [ ] White
- [ ] Other Pacific Islander
- [ ] Undisclosed

**Ethnicity**
- [ ] Hispanic or Latino
- [ ] Non-Hispanic or Latino
- [ ] Undisclosed

**EMPLOYED**
- [ ] Full Time
- [ ] Part-Time
- [ ] Unemployed
- [ ] Self Employed
- [ ] Retired
- [ ] Student
- [ ] N/A
- [ ] Other ______

**EMPLOYER NAME**

**EMPLOYER PHONE#**

**AGRICULTURAL WORKER OR DEPENDANT:**
- [ ] Yes
- [ ] No

**VETERAN:**
- [ ] Veteran
- [ ] Veteran Family Member
- [ ] N/A

---

**EMERGENCY CONTACT INFORMATION**

**List Person we may contact in case of emergency**

Name: ____________________________________________  Relationship: ____________________________

Phone: ________________________________

- [ ] Check if OK to leave message at your home phone
- [ ] Check if OK to leave message on cell phone
- [ ] Check if OK to leave message at work phone
- [ ] Check if OK to say we are from Hui Mālama Ola Nā ‘Ōiwi when we write or call?

**How did you hear about us?**

- [ ] Hui Mālama Staff
- [ ] Family/Friend
- [ ] Physician Referral
- [ ] Website
- [ ] Community Event
- [ ] Flyer
- [ ] Newsletter
- [ ] Newspaper
- [ ] Social Media
- [ ] Search Engine
- [ ] Other ________________________________

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**HUI MĀLAMA OLA NĀ ‘ŌIWI-Authorization and Release Form**

I hereby authorize the release of information which has been obtained about me. I understand that this information will be used for statistical purposes and/or to help me receive the benefits to which I may be entitled. My name will not be used, only a code number.  **Initial Here: ______**

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

I give Hui Mālama Ola Nā ‘Ōiwi permission to verify the financial and insurance information provided by me to determine eligibility for Hui Mālama Ola Nā ‘Ōiwi health services. I understand it is my responsibility to keep Hui Mālama Ola Nā ‘Ōiwi informed of any changes in my family’s income and insurance status. **Initial Here: _____________**

All information on this form is true and accurate to the best of my knowledge:

_________________________  __________________________
Signature (Patient Party/Legal Guardian)  Date

_________________________  __________________________
Please Print your Name Here  Witness

---

**FORM: Patient Client Registration**

Effective: 1/2019

**Staff Signature: ___________________________  Date: _____________**
HEALTH HISTORY
CONFIDENTIAL

Patient Name___________________________________________________Today’s Date___________________________
Age___________Birthdate___________________________Date of last physical examination________________________
What is your reason for visit? ________________________________________PCP______________________________

### CONDITIONS
Check (✓) symptoms you have or have had in the past.

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Symptom</th>
<th>Symptom</th>
<th>Symptom</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS</td>
<td>Chemical Dependence</td>
<td>High Cholesterol</td>
<td>Prostate Problem</td>
</tr>
<tr>
<td>Alcoholism</td>
<td>Chicken Pox</td>
<td>HIV Positive</td>
<td>Psychiatric Care</td>
</tr>
<tr>
<td>Anemia</td>
<td>Diabetes</td>
<td>Kidney Disease</td>
<td>Rheumatic Fever</td>
</tr>
<tr>
<td>Anorexia</td>
<td>Emphysema</td>
<td>Liver Disease</td>
<td>Scarlet Fever</td>
</tr>
<tr>
<td>Appendicitis</td>
<td>Epilepsy</td>
<td>Measles</td>
<td>Stroke</td>
</tr>
<tr>
<td>Arthritis</td>
<td>Glaucoma</td>
<td>Migraine Headaches</td>
<td>Suicide Attempt</td>
</tr>
<tr>
<td>Asthma</td>
<td>Goiter</td>
<td>Miscarriage</td>
<td>Thyroid Problems</td>
</tr>
<tr>
<td>Bleeding Disorders</td>
<td>Gonorrhea</td>
<td>Mononucleosis</td>
<td>Tonsillitis</td>
</tr>
<tr>
<td>Breast Lump</td>
<td>Gout</td>
<td>Multiple Sclerosis</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>Bronchitis</td>
<td>Heart Disease</td>
<td>Mumps</td>
<td>Typhoid Fever</td>
</tr>
<tr>
<td>Bulimia</td>
<td>Hepatitis</td>
<td>Pacemaker</td>
<td>Ulcers</td>
</tr>
<tr>
<td>Cancer</td>
<td>Hernia</td>
<td>Pneumonia</td>
<td>Vaginal Infections</td>
</tr>
<tr>
<td>Cataracts</td>
<td>Herpes</td>
<td>Polio</td>
<td>Venereal Disease</td>
</tr>
</tbody>
</table>

### HEALTH MAINTENANCE

#### MEN only
- Breast lump
- Erection difficulties
- Lump in testicle
- Penis discharge
- Sore on penis
- Colonoscopy
- Other___________________

#### WOMEN only
- Abnormal pap smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Colonoscopy
- Vaginal discharge
- Other___________________

**Date of last menstrual period________________**
**Date of last Pap Smear________________**
**Have you had a mammogram? __________**
**Are you pregnant? _________**
**Number of children________**

### DO YOU EXERCISE?  □ Yes  □ No

If yes, answer the following

List type of exercise:

How often?

How long?

Other activities:

### ALLERGIES
To medications or substance

Pharmacy Name:

Location

### MEDICATIONS
List medications you are currently taking
### FAMILY HISTORY
Fill in health information about your immediate family.

<table>
<thead>
<tr>
<th>Relation</th>
<th>Age</th>
<th>State of Health</th>
<th>Age at Death</th>
<th>Cause of Death</th>
<th>Disease</th>
<th>Relationship to you</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Arthritis, Gout</td>
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<td></td>
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<td></td>
<td>Asthma, Hay Fever</td>
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<td></td>
<td>Cancer</td>
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<td>Chemical Dependency</td>
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<td></td>
<td></td>
<td>Diabetes</td>
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<td>Heart Disease, Strokes</td>
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<td>High Blood Pressure</td>
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<td></td>
<td>Kidney Disease</td>
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<td></td>
<td></td>
<td></td>
<td>Tuberculosis</td>
<td></td>
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<td></td>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

### PAST MEDICAL HISTORY

### PREGNANCY HISTORY

<table>
<thead>
<tr>
<th># of Pregnancies</th>
<th>Term/Preterm</th>
<th>Abortion/Miscarriage</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

### HEALTH HABITS
Check (✓) which substances you use and describe how much you use.

- Alcohol
- Caffeine
- Street Drugs
- Tobacco
- Vaping/E-cig
- Other

### PAST SURGICAL HISTORY

<table>
<thead>
<tr>
<th>YEAR</th>
<th>FACILITY</th>
<th>TYPE OF SURGERY AND OUTCOME</th>
<th>OTHER</th>
</tr>
</thead>
<tbody>
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</tr>
</tbody>
</table>

### OCCUPATIONAL CONCERNS
Check (✓) if your work exposes you to the following:

- Stress
- Hazardous
- Heavy Lifting
- Other

Your Occupation:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor, if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Date
Hui Mālama Ola Nā ‘Ōiwi
Hawai‘i Island Health Care System

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

TO: 


PATIENT NAME: 


DATE OF BIRTH: 


PLEASE SEND INFORMATION TO: Hui Mālama Ola Nā ‘Ōiwi-Family Medicine Clinic 82 Pu‘uhonu Place, Suite 209 Hilo, Hawai‘i 96720 P: (808) 796-3125 Fax: 1-866-372-2766

Purpose of Release:

☐ Transfer of Care/Changing Primary Care Physician
☐ OTHER: (please specify)

Please release the following:

☐ Complete Chart/ALL Records
☐ OTHER: (please specify)

Protected or Sensitive Information pertaining to: (please INITIAL all that apply)

By initialing, I specifically authorize release of the following protected or sensitive information:

☐ HIV/AIDS
☐ ALCOHOL OR DRUG USE
☐ BEHAVIORAL/MENTAL HEALTH
☐ OTHER
☐ ALL OF THE ABOVE

Term: I understand that this authorization will remain in effect:

☐ From the date of this Authorization until the _____ day of __________, 20____.
☐ Until the Provider fulfills this request.
☐ Until the following event occurs: ______________________________________

Redisclosure: I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don’t sign it will not affect the commencement, continuation or quality of my treatment at HUI MĀLAMA OLA NĀ ‘ŌIWI Family Medicine clinic. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the HUI MĀLAMA OLA NĀ ‘ŌIWI Family Medicine clinic at the address listed above. The revocation will be effective immediately upon my health care provider’s receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.

I hereby authorize and request the release of information on myself, or that of my minor child listed above to be released to HUI MĀLAMA OLA NĀ ‘ŌIWI. I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse or drug and alcohol abuse.

____________________________________________________________________
Signature of Patient, parent or legal guardian of minor Date

If not the patient, name and relationship of person completing form (please print)

This consent shall expire on the date specifically indicated above and may be revoked by the signer at any time. Incomplete information will delay processing. Use of this information for any other than the stated purpose is prohibited. It is for the use of the designated recipient only and cannot be provided to any other agency.
PATIENT INFORMATION SHEET

APPOINTMENT POLICY

Hui Mālama Ola Nā ‘Ōiwi is here to serve our community and to help meet the health care needs of our native Hawaiian people. Patients are seen by appointment only. Walk-in patients without an appointment may be seen based on medical necessity and if the clinic has availability.

If you have a scheduled appointment and need to cancel, please notify us immediately so we can offer that time/space to other patients needing to be seen. As a courtesy to all our patients, if you are 15 minutes late for your scheduled appointment, you will be asked to reschedule.

PRESCRIPTION POLICY

All prescription refills must be approved by the Physician, and require up to three working days (72 hours) to process. PLEASE PLAN AHEAD. For example, do not call the day before your medication runs out. Give yourself at least one week of medicine left, then call our office for a refill. Prescription refills will only be approved if the Physician feels it is safe for you to receive them; you may be required to come in before your prescription is refilled.

When calling our office for a refill, don’t forget to include the name of the medication you are taking, the dosage (i.e. 50 mg), how often you take it, the name of the pharmacy you would like your medication filled at, and a current phone number in case we need to reach you regarding your medications.

Our Physicians here at Hui Mālama Ola Nā ‘Ōiwi do not believe that chronic pain is best treated with narcotic pain medication. If you require long-term addictive pain medications, we will help you find an alternative, or refer you to pain management services.

I have read and understand the information said above. By signing below I agree to abide by the rules set forth on this statement.

Print Name: ___________________________ Signature: ___________________________
Witness: ___________________________ Date: ___________________________
ACKNOWLEDGMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (808) 969-9220 or on HMONŌ’s website at www.HMONO.org or by requesting one at the HMONŌ offices.

________________________
(Date)

________________________
(Signature*)

________________________
(Print or Type Name)

*As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

________________________
(Signature)

________________________
(Relationship)

________________________
(Date)
HIPAA Right of Access Form for Family Member/Friend/Representative

I, ________________________________, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: ________________________________ Relationship: __________________

Address: ________________________________ Phone: ______________________

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

☐ A. Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) OR

☐ B. Disclose my health record, as above, BUT do not disclose the following (check as appropriate):

☐ Mental health records
☐ Communicable diseases (including HIV and AIDS)
☐ Alcohol/drug abuse treatment
☐ Other (please specify):

______________________________

This authorization shall be effective until (Check one):

☐ All past, present, and future periods, OR

☐ Date or event: ____________________________ unless revoked. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

__________________________________________
Name of Individual Giving this Authorization

__________________________________________
Date of Birth

__________________________________________
Signature of Individual Giving this Authorization

__________________________________________
Date
Live longer and feel better together....

Call (808) 796-3125
Our Mission: To provide health services and enhance the quality of life among our Native Hawaiian People.

Our Vision: We envision a health community, Native Hawaiians and their ‘Ohana, where everyone achieves their full potential-spiritually, mentally and physically.

Mission and Vision Statement:

‘O Hui Mālama Ola Nā ‘Ōiwi mākou.
We are the group that takes care of the health of Hawaiian people.

Eia ke kuleana: Ho‘oulu ola ka lāhui Hawai‘i.
Our Mission is to uplift the health of the Hawaiian nation.

Mālama iā Moku o Keawe,
We will take care of Hawai‘i Island,

Mālama i nā kuaʻāina,
Country and rural areas,

Mālama i kou olakino,
Your physical, spiritual and mental body,

Mālama i nā mea Hawai‘i.
And Hawaiian culture and practices.

E hoʻoikaika a ola ka lāhui Hawai‘i.
We envision a strong and healthy Hawaiian nation.
Patient Rights

Patients’ rights include rights described below and any other rights that may be described in the Patient Rights Handbook or otherwise protected by law:

1. Receive care regardless of race, religion, national origin, disability, sex, sexual orientation, age or source of payment for care.

2. Be seen in a private and secure area during treatment within the capacity of Hui Mālama Ola Nā ‘Ōiwi Family Medical Clinic.

3. Know the name and specialty of the physician or other person responsible for your care or for coordinating your care.

4. The patient has the right to be referred to other services available upon request.

5. Be actively involved in the decisions regarding your care.

6. Refuse treatment to the extent permitted by law and be informed of the potential consequences of that refusal.

7. Refuse to participate in educational, research, or experimental treatment.

8. Be informed of your condition and the treatment(s) recommended, including information about the potential benefits, risks and alternative treatments regarding any surgery or other intrusive treatment.

9. Refuse to sign consent for HMONO/FMC until you understand what you are signing.

10. Designate a family member or representative of your choice to make informed decisions about your care, if you so choose.

11. Formulate advance directives and have them followed.

12. Protection of the confidentiality of your medical records and communications to the extent provided by law.

13. Inspect your medical records and ask for a copy of your medical records within the limits of the law (copying fees may be applicable).

14. Obtain explanations of monies owed to HMONO/ or receive an itemized bill reflecting your costs.

15. Express concerns or grievances regarding your care or treatment.
Patient Responsibilities

Patient responsibilities include the following as well as any other responsibilities set forth in the Patient Rights and Responsibilities Handbook, or as imposed by any applicable law or regulation:

1. Treat all other persons (patients, family members, vendors, staff members) at HMONO/FMC with courtesy, dignity and respect at all times.

2. For yourself, family members, friends and caregivers to be clean and sober, and not under the influence of alcohol or drugs.

3. Respect the rights and property of HMONO/FMC, its staff, vendors and other patients, and follow the rules and regulations of HMONO/FMC at all times.

4. Take an active part in developing the treatment plan for your care and cooperate with the treatment you and your provider have agreed upon.

5. Report any changes in your condition or symptoms to HMONO/FMC.

6. Notify any member of the healthcare team, if you do not understand.

7. Provide information about your care and treatment, or about any information you are provided or any papers you are requested to complete.

8. Follow up and be on time for scheduled appointments and cancel appointments before the scheduled appointment according to HMONO/FMC policies. This includes any specialty, labs, diagnostics or referral appointments made for you.

9. Provide accurate and complete information about all matters pertaining to your health, including an accurate medical history including past illnesses, medications, allergies, hospitalizations, family and social histories.

10. Provide accurate information for registration, billing, payment, informed consents and promptly notify HMONO/FMC of any changes in your address, phone number, insurance coverage and/or contact information.

11. Promptly pay any financial obligations to HMONO/FMC or make a satisfactory form of payment arrangement with HMONO/FMC.

12. Keep your personal belongings in a safe place and do not bring valuables to HMONO/FMC. Lost or stolen personal items are not the responsibility of HMONO/FMC.

13. Promptly inform a member of your health team or the clinical manager of any concerns you may have regarding your care.
HIPAA NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED BY HUI MĀLAMA OLA NĀ ‘ŌIWI

If you have any questions about this notice, please contact Hui Mālama Ola Nā ‘Ōiwi, attention Executive Director (808) 969-9220.

WHO WILL FOLLOW THIS NOTICE:
Hui Mālama Ola Nā ‘Ōiwi (HMONO).

This notice describes our privacy practices. All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION
We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:
● Make sure that health information that identifies you is kept private.
● Give you this notice of our legal duties and privacy practices with health information about you.
● Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU
The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other personnel who are consulted to take x-rays, to perform lab test, to have prescriptions filled, or for other treatment purposes; and to others involved in taking care of you. They may work at our offices, at the hospital if you are hospitalized under our supervision, or at another doctor’s office, lab pharmacy, or other health care provider to whom we may refer you for example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian at the hospital if you have diabetes so that we can arrange for appropriate meals. We may also disclose health information about you
to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

**For Payment:** We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about your office visit so your health plan will pay us or reimburse you for the visit. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether you plan will cover the treatment.

**For Health Care Operations:** We may use and disclose health information about you for operations of our health care practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.

**Appointment Reminders:** We may use and disclose health information to contact you as a reminder that you have an appointment. Please let us know if you do not wish to have us contact you concerning your appointment, or if you wish to have us use a different telephone number or address to contact you for this purpose.

**As Required By Law:** We will disclose health information about you when required to do so by federal, state, or local law.

**To Avert a Serious Threat to Health or Safety:** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the treat.

**Military and Veterans:** If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

**Workers’ Compensation:** We may release health information about you for workers’ compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

**Public Health Risks:** We may disclose health information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify person or organization required to receive information on FDA-regulated
products;
• to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
• to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in a response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release health information if asked to do so by a law enforcement official:
• in reporting certain injuries, as required by law, gunshot wounds, burns, injuries to perpetrators of crime;
• in response to a court order, subpoena, warrant, summons or similar process;
• to identify or locate a suspect, fugitive, material witness, or missing person:
  - Name and address;
  - Date of birth or place of birth;
  - Social Security number;
  - Blood type or Rh factor;
  - Type of injury;
  - Date and time of treatment and/or death, if applicable; and
  - A description of distinguishing physical characteristics.
• about the victim of a crime, if the victim agrees to disclosure or under certain limited circumstances, we are unable to obtain the person’s agreement;
• about a death we believe may be the result of criminal conduct;
• about criminal conduct at our facility; and
• in emergency circumstances to report a crime; the location of the crime or victim; or the identity, description, or location of the person who committed the crime.

Coroners, Health Examiners and Funeral Directors: We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may release health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose health information about you to authorized federal officials so they may provide protection to the President,
Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU
You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records. This does not include psychotherapy and substance abuse notes.

To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to Hui Mālama Ola Nāʻōiwi, attention Executive Director. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies and services associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment, your request must be made in writing, submitted to Hui Mālama Ola Nāʻōiwi, attention Executive Director. In addition, you must provide a reason that supports your request for an amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
- is not part of the health information kept by or for our practice;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures: You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.
To request this list of disclosures, you must submit your request in writing to Hui Mālama Ola Nā ʻŌiwi, attention Executive Director. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures in writing within 30 days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; but this date will not exceed a total of 60 days from the date you made the request.

**Right to Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we restrict a specified nurse from use of your information, or that we not disclose information to your spouse about a surgery you had.

*We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you.*

If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request in writing to Hui Mālama Ola Nā ʻŌiwi, attention Executive Director. In your request, you must tell us what information you want to limit and to whom you want the limits to apply; for example, use of any information by a specified nurse, or disclosure of specified surgery to your spouse.

**Right to Request Confidential Communications:** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box.

To request confidential communications, you must make your request in writing to Hui Mālama Ola Nā ʻŌiwi, attention Executive Director. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

**Right to a Paper Copy of This Notice:** You have the right to obtain a paper copy of this notice at any time. To obtain a copy, please request it from any Hui Mālama Ola Nā ʻŌiwi staff member.

You may also obtain a copy of this notice from our website, [www.hmono.org](http://www.hmono.org). Even if you have received a notice electronically, you still retain the right to receive a paper copy upon request.

**CHANGES TO THIS NOTICE**

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any
information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint. You may either file a complaint with us or with the Secretary of Health and Human Services. To file a complaint with us, contact Hui Mālama Ola Nā ʻŌiwi, attention Executive Director. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION
Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE
We will request that you sign a separate form or notice acknowledging you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name, date. This acknowledgement will be filed with your records.