Hui Mālama Ola Nā ʻŌiwi

Native Hawaiian 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***

Patient Legal Last Name	Suffix	Patient First Name &Middle Initial	Nickname
Residence Address		City/Town	Zip code
Mailing/Other Address		City/Town	Zip Code

Home Phone #	Cell Phone #	Work Phone #	Email
Date of Birth:		Age:	Social Security Number
Name of Primary Care Provider:		Were you referred? ☐ Yes ☐ No Who referred you: _____	

Marital Status
◯ Single ◯ Partner
◯ Married ◯ Divorced
◯ Legally Separated ◯ Widowed

Gender: ◯ Male ◯ Female ◯ Transgender Male/Female ◯ Transgender Female/Male ◯ Other ◯ Choose not to disclose

Sexual Orientation: ◯ Straight ◯ Gay/Lesbian ◯ Bisexual ◯ Something else ◯ Don't Know ◯ Choose not to disclose

RESPONSIBLE PARTY INFORMATION

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

Name:	Relationship to Patient	Contact #
Mailing address:	City/State:	Zip code:

PRIMARY INSURANCE INFORMATION: ☐ **None** ☐ **Medical**

Primary Insurance:	Membership ID#	Group#
Subscriber Name:	Date of Birth:	Plan#

SECONDARY INSURANCE INFORMATION: ☐ **None** ☐ **Medical**

Secondary Insurance	Membership ID#	Group#
Subscriber Name:	Date of Birth	Plan#

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: _____**

Are you pregnant? ◯ **Yes** ◯ **No** ***If yes,** have you received prenatal care in your first trimester of pregnancy? ◯ **Yes** ◯ **No**	**Are you a parent of a child under 3?** ◯ **Yes** ◯ **No** ***If yes,** has your child received the 24-25 recommended immunization shots? ◯ Yes ◯ No ☐ I don't know	**Are you diagnosed with any of the following?** ☐ **Diabetes** ☐ **Hypertension** ☐ **Cancer**

HOUSEHOLD INFORMATION

Income $ _____ ☐ Monthly ☐ Annual Family Size _____ ◯ I don't want to disclose income information

Homeless

- ◯ Not Homeless
- ◯ Homeless Shelter
- ◯ Transitional
- ◯ Doubling Up
- ◯ Street
- ◯ Other _____
- ◯ Yes, but unknown

If homeless, for how long: _____

Primary Language

- ◯ English
- ◯ Hawaiian
- ◯ Other_____

Are you Hawaiian? ◯ **Yes** ◯ **No**

Ethnicity

- ◯ Hispanic or Latino
- ◯ Non-Hispanic or Latino
- ◯ Undisclosed

Race (check all that apply)

- ☐ Native Hawaiian
- ☐ Asian
- ☐ White
- ☐ Other Pacific Islander
- ☐ Undisclosed
- ☐ Black
- ☐ American Indian or Alaska Native

EMPLOYED

◯ Full Time ◯ Part-Time ◯ Unemployed ◯ Self Employed ◯ Retired ◯ Student ◯ N/A ◯ Other _____

EMPLOYER NAME	**EMPLOYER PHONE#**

AGRICULTURALWORKER 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 ʻŌiwi 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**_____

HUI MĀLAMA OLA NĀ ʻŌIWI-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 ʻŌiwi permission to verify the financial and insurance information provided by me to determine eligibility for Hui Mālama Ola Nā ʻŌiwi health services. I understand it is my responsibility to keep Hui Mālama Ola Nā ʻŌiwi 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.

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

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_____

ALLERGIES To medications or substance	**MEDICATIONS** List medications you are currently taking
Pharmacy Name:	
Location	

All information is strictly confidential

FAMILY HISTORY Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓), if your blood relatives or you have had any of the following: Disease	Relationship to you
					Arthritis, Gout	
					Asthma, Hay Fever	
					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

PAST SURGICAL HISTORY

YEAR	FACILITY	TYPE OF SURGERY AND OUTCOME

PREGNANCY HISTORY

# of Pregnancies	Term/ Preterm	Abortion/ Miscarriage

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates. _____

OCCUPATIONAL CONCERNS

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

	Stress
	Hazardous
	Heavy Lifting
	Other

Your Occupation:

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

	Alcohol	
	Caffeine	
	Street Drugs	
	Tobacco	
	Vaping/E-cig	
	Other	

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 ʻŌiwi

Native Hawaiian Health Care System

PATIENT INFORMATION SHEET

APPOINTMENT POLICY

Hui Mālama Ola Nā ʻŌiwi 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.

Please provide the following information when calling our office for medication refills: the name of the medication, the dosage (i.e. 50 mg), directions as they appear on your medication bottle, the name of the pharmacy where you receive your refills, and a current phone number.

Our Physicians here at Hui Mālama Ola Nā ʻŌiwi 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:_____

Hui Mālama Ola Nā ʻŌiwi

Native Hawaiian Health Care System

Sliding Fee Discount Program

Hui Malama Ola Na `Oiwi (HMONO) accepts all Medicare and Medicaid insurance plans, as well as most major insurances. The Sliding Fee Discount is in place to meet the needs of the uninsured or underinsured, providing reduced costs on services for those who qualify. Services are offered regardless of insurance status or ability to pay.

WHAT IS THE SLIDING FEE DISCOUNT PROGRAM? A program designed to help cover your out-of-pocket expenses for services provided by HMONO.

HOW DO I PARTICIPATE? Fill out a Sliding Fee Discount Application. All patients are welcome to apply. Your discount, if any, depends on your income and family size. You can apply at any time. Our staff can help you fill out the application. If you qualify, you must reapply annually.

HOW MUCH IS THE DISCOUNT? Depending on your income and family size, this program allows patients to pay a set fee. Income categories are based on the Federal Poverty guidelines. Please see our Sliding Fee Discount Application for income and family member definitions.

	Level A	**Level B**	**Level C**	**Level D**
% of poverty level	100%	101%-138%	139%-150%	151%-200%

Family Size	**Maximum monthly earnings to qualify for discount.**			
1	$ 1,303	$ 1,797	$ 1,954	$ 2,605
2	$ 1,755	$ 2,422	$ 2,633	$ 3,510
3	$ 2,208	$ 3,046	$ 3,311	$ 4,415
4	$ 2,660	$ 3,671	$ 3,990	$ 5,320
5	$ 3,113	$ 4,295	$ 4,669	$ 6,225
6	$ 3,565	$ 4,920	$ 5,348	$ 7,130
7	$ 4,018	$ 5,544	$ 6,026	$ 8,035
8	$ 4,470	$ 6,169	$ 6,705	$ 8,940
Maximum amount charged per visit	**$10**	**$20**	**$25**	**$50**

*Discounted Fees for Medical visit, Behavioral Health visit, and Traditional Healing Services
****above 200% - no discount given****

ACKNOWLEDGMENT I am aware that HMONO offers a sliding fee discount for qualified applicants. HMONO will not deny services based on a patient's ability to pay.

☐ **I would like an application to be considered for a sliding fee discount.**

☐ **I am not interested in receiving a sliding fee application at this time. I understand I may request an application at any time in the future if my circumstances change.**

Patient Name _____ Patient Signature _____ Date _____

Hui Mālama Ola Nā ʻŌiwi

Native Hawaiian Health Care System

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 revoke it. (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

Hui Mālama Ola Nā ʻŌiwi

Native Hawaiian Health Care System

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

TO: _____

_____

_____

PATIENT NAME: _____

DATE OF BIRTH: _____

PLEASE SEND INFORMATION TO: **Hui Mālama Ola Nā ʻŌiwi-Family Medicine Clinic**
82 Puʻuhonu Place, Suite 209
Hilo, Hawaiʻi 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 ʻŌIWI 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 ʻŌIWI 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 ʻŌIWI**. 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.