Ho`ola Lahui Hawai`i
Kaua`i Community Health Center

HO'OLA LAHUI HAWAI'I
KAUA'I COMMUNITY HEALTH CENTER
Medical & Behavioral Health Services

Client Registration Form - Please Complete All Questions

Print Form

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

Ho'ola Cares

If you are uninsured, you may apply for a discount according to your family size and income amounts. If you qualify, you would pay a percentage of any billable charges. If you are interested in this discount, please inform us.

CLIENT / PATIENT INFORMATION:

Prefix _____ Last Name: _____ Suffix _____ First Name: _____ MI _____

Previous Name _____ Mailing Address: _____

City: _____ State _____ Zip Code: _____ Residence Address: _____ City: _____ Zip Code: _____

Home Phone No: _____ Cell Phone No. _____ Work Phone No. _____ Ext. _____

Name of Primary Doctor (PCP) : _____ Date of Birth: _____ Age _____ Gender: ☐ Male ☐ Female

Were you referred? ☐ No ☐ Yes

Who Referred You _____ Social Security # _____

Marital Status: ☐ Single ☐ Married ☐ Widow ☐ Partner ☐ Divorced ☐ Legally Separated

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

Employer Name _____

Patient E-mail: _____

Employment Status **(Select One)**

☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired ☐ Active Military

EMERGENCY CONTACT INFORMATION:

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

Name: _____ Relationship: _____ Phone No.: _____

Do you have any Disabilities? ☐ Yes ☐ No

Family Monthly Income: **(Please provide an approximate estimate)** **Monthly Income:** _____ **Family Size:** _____ ☐ I do not want to disclose Income Information

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

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

☐ Self Pay (Please check here if you do not want an insurance claim submitted and wish to pay for entire services rendered at time of service.

☐ Check If Ok to leave message at your Home Phone ☐ Check If Ok to leave message on Cell Phone ☐ Check Box If Ok to leave message at Work Phone

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

RACE (SELECT ONE ONLY)

☐ American Indian or Alaska Native
☐ Asian Indian ☐ Black or African American
☐ Chinese ☐ Declined to Specify ☐ Filipino
☐ Guamanian or Chamorro ☐ Japanese
☐ Korean ☐ Native Hawaiian
☐ Other Asian ☐ Other Pacific Islander
☐ Samoan ☐ Vietnamese ☐ White

ETHNICITY (SELECT ONE ONLY)

☐ Chicano ☐ Cuban
☐ Declined to Specify
☐ Hispanic or Latino
☐ Mexican ☐ Mexican American
☐ Not Hispanic or Latino
☐ Puerto Rican

WORKER STATUS (If applicable) ☐ Migrant ☐ Seasonal

Additional Information ☐ Check Box if you live in Public Housing

Primary Language (Please list below) _____

Do you need an Interpreter? ☐ Yes ☐ No

Are you a Veteran? ☐ Yes ☐ No

Who may we talk to about your health?

Name: _____

Relationship: _____ Phone No.: _____

PRIMARY Medical Insurance Information: **(A copy of all insurance cards are required)** ☐ None

Primary Insurance: _____ Subscriber Name: _____

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

SECONDARY Medical Insurance Information: **(A copy of all insurance cards are required)** ☐ None

Secondary Insurance: _____ Subscriber Name: _____

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

Non-disclosure to Health Insurance:

I do not want my insurance company billed or notified of today's services. I understand that by doing this I am obligated to pay prior to services being rendered to myself or dependent.

Date: _____ **Initial Here:** _____

RESPONSIBLE PARTY INFORMATION

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

Name: _____ Relation to Patient _____ Contact Phone # _____

Mailing Address: _____ City: _____ Zip Code: _____

PARENT INFO (IF MINOR)

MOTHER NAME _____ PHONE# _____ EMAIL _____

FATHER NAME _____ PHONE# _____ EMAIL _____

Ho'ola Lahui Hawai'i - Authorization and Release Form

I authorize this office to release to the named insurance company any information necessary to secure insurance payment. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand I am responsible for all charges regardless of insurance coverage. **Date** _____ **Initial Here:** _____

I authorize and consent to any diagnostic and/or medical/dental treatment under the instruction of the attending physician and/or dentist for which my dependent or I have sought care.

Date _____ **Initial Here:** _____

I grant permission to view prescription history from external sources. **Date** _____ **Initial Here:** _____

I give Ho'ola Lahui Hawai'i (Kaua'i Community Health Center) permission to verify the financial and insurance information provided by me to determine eligibility for Ho'ola Lahui Hawai'i (Kaua'i Community Health Center) services. I understand it is my responsibility to keep Ho'ola Lahui Hawai'i (Kaua'i Community Health Center) informed of any changes in my families income and insurance status.

Date _____ **Initial Here:** _____

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

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

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

The information provided is accurate and complete to the best of my knowledge and is only to be used for my treatment, billing, processing of insurance claims, and/or for qualification for services to which I may be eligible.

Date _____ **Initial Here:** _____

I understand that there is a notification period of 24 hours prior to my appointment or my account will be charged $25.00 for any appointment(s) not kept. **Date:** _____ **Initial Here:** _____

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

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

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

(Staff Member verified completion of Registration Form)
Reviewed By Ho'ola Staff: (Print Name & Date) _____ Date _____