HOʻŌLA LĀHUI HAWAIʻI
KAUAʻI COMMUNITY HEALTH CENTER

Medical & Behavioral Health Services

Patient Registration Form - Please Complete All Questions

Hoʻōla 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 the discount, please inform us.

PATIENT INFORMATION

Prefix ____ Last Name _____ Suffix ____ First Name _____ M.I. _____

Previous Name _____ Preferred Name _____

Date of Birth _____ Sex: □ Male □ Female Social Security Number _____

Mailing Address_____ City _____ State _____ Zipcode _____

Residence Address _____ City _____ State _____ Zipcode _____

Home Phone _____ Cell Phone _____ Work Phone _____ Ext _____

It is okay to leave a health related message at (Check ALL that apply): □ Home Phone □ Cell Phone □ Work Phone

Email Address _____

STATUS INFORMATION

Housing Status (Select ONE only)
□ Not Homeless □ Homeless Shelter □ Unhoused/On the Street □ Unknown
□ Transitional Housing □ Doubling Up □ Permanent Supportive Housing □ Other

Do you live in Public Housing? □ Yes □ No

Marital Status (Select ONE): □ Single □ Married □ Widow □ Partner □ Divorced □ Legally Separated

Student Status: □ Full Time □ Part Time □ Not a Student **Veteran**? □ Yes □ No

Employment Status: (Select ONE)
□ Full Time □ Part Time □ Not Employed
□ Self-Employed □ Retired □ Active Military

Employer Name _____ **Worker Status** (if applicable): □ Seasonal □ Migrant

Any disabilities? □ Yes □ No

RACE, ETHNICITY, AND LANGUAGE

Race (Select ONE only)
□ Asian Indian □ Vietnamese □ Samoan
□ Chinese □ Other Asian □ Black or African American
□ Filipino □ Native Hawaiian □ American Indian or Alaska Native
□ Japanese □ Other Pacific Islander □ White
□ Korean □ Guamanian or Chamorro □ Decline to Specify

Ethnicity (Select ONE only)
□ Mexican, Mexican American, Chicano/a □ Other Hispanic, Latino/a or Spanish Origin
□ Puerto Rican □ Not Hispanic, Latino/a, or Spanish Origin
□ Cuban □ Decline to Specify

Primary Language _____ Do you need an interpeter? □ Yes □ No

Native Hawaiian Ancestry □ Yes □ No

CONTACTS

EMERGENCY CONTACT INFORMATION

Person we may contact in case of emergency (if possible, someone from outside the home)

Name _____ Relationship _____ Phone No. _____

AUTHORIZED CONTACT INFORMATION

Who may we talk to about your health?

Name _____ Relationship _____ Phone No. _____

PARENT INFORMATION (For Minor Patients)

Mother Name _____ Phone _____ Email _____

Father Name _____ Phone _____ Email _____

CURRENT PROVIDER

Name of Primary Doctor (PCP) _____

Were you referred? ☐ Yes ☐ No Who referred you? _____

BILLING & INSURANCE INFORMATION

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

Primary Insurance Provider _____ Subscriber Name _____

Subscriber ID # _____ Group # _____ Date of Birth _____ SSN _____

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

Secondary Insurance Provider _____ Subscriber Name _____

Subscriber ID # _____ Group # _____ Date of Birth _____ SSN _____

Self-Pay/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 dependents.

Date _____ Initials _____

RESPONSIBLE PARTY INFORMATION (For Payment)

Relationship to Patient (Select ONE) ☐ Self ☐ Spouse ☐ Parent ☐ Guardian

Name _____ Contact Phone: _____

Mailing Address _____ City _____ State _____ Zipcode _____

INCOME & FAMILY SIZE

Family Size: _____ Approximate Family Income $_____ ☐ Monthly ☐ Annual

☐ Decline to disclose income information

(To be completed by HLH Staff)

Ho'ōla Cares SFS Eligibility

Level: ☐ SFS A ☐ SFS B ☐ SFS C ☐ SFS D ☐ SFS E **Application on File**? ☐ Yes ☐ No

HOʻŌLA LĀHUI HAWAIʻI - AUTHORIZATIONS AND RELEASE FORM

Check each box. Initial and Date on the right.

TO INSURANCE COMPANY - 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 regardleess of insurance coverage.	☐	**Initials** _____ **Date** _____
TO TREATMENT - 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.	☐	
TO PRESCRIPTION HISTORY - I grant permission to view prescription history from external sources.	☐	
TO VERIFY FINANCIAL AND INSURANCE INFORMATION - I give to Hoʻōla Lāhui Hawaiʻi (Kauaʻi Community Health Center) permission to verify the financial and insurance information provided by me to determine eligibility for Hoʻōla Lāhui Hawaiʻi (Kauaiʻi Community Health Center) services. I understand that it is my responsibility to keep Hoʻōla Lāhui Hawaiʻi (Kauaʻi Community Health Center) informed of any changes in my family's income and insurance status.	☐	

HOʻŌLA LĀHUI HAWAIʻI - ACKNOWLEDGEMENTS

Check each box. Initial and Date on the right.

I have received a copy of the Hoʻōla Lāhui Hawaiʻi PATIENT HANDBOOK which includes a copy of the **HIPAA Notice of Privacy Practices** and **Patient Rights and Responsibilities**, including Hoʻōla Lāhui Hawaiʻi's **Grievance Procedure**.	☐	**Initials** _____ **Date** _____
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.	☐	
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 appointments not kept.	☐	
I understand that there is a $25.00 service charge for any/all returned checks.	☐	

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

If Other signing, please PRINT your name here _____ Witness _____

Relationship to Patient _____

----------For Office Use Only----------

Reviewed by HLH Staff Print Name _____ Date _____