

*Please fill in all information requested, as it helps us to better serve you.*

*Please be assured that patient information is confidential, and is only used for Hawai'i Island Community Health Center purposes.*

### ADULT PATIENT INFORMATION SUMMARY

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Street Address:\* \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex at Birth:  Male  Female \* Required for prescriptions

Please select preference for appointment reminders: Preferred Phone:  Home  Cell Preferred Method:  Voice  Email  Text

Marital Status:  Single  Married  Legally Separated  Divorced  Widowed

Race:	<input type="checkbox"/> Native Hawaiian	Ethnicity:	<input type="checkbox"/> Latino/Hispanic	Primary Language:	<input type="checkbox"/> English
	<input type="checkbox"/> Other Pacific Islander		<input type="checkbox"/> Not Latino/Hispanic		<input type="checkbox"/> Spanish
	<input type="checkbox"/> Asian				<input type="checkbox"/> Marshallese
	<input type="checkbox"/> Black/African American				<input type="checkbox"/> Russian
	<input type="checkbox"/> White/Caucasian				<input type="checkbox"/> Filipino
	<input type="checkbox"/> Native American Indian/Alaskan Native				<input type="checkbox"/> Chinese
	<input type="checkbox"/> More than one race				<input type="checkbox"/> Japanese
					<input type="checkbox"/> Sign Language

**Would you like to have an interpreter?**

Yes  No

Employment Status:  Employed  Retired  Disabled  Self-Employed  Unemployed  Part-Time Student  Full-Time Student

If Employed: Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Phone #: \_\_\_\_\_

### PERSON(S) RESPONSIBLE FOR PAYMENT

*The guarantor is the parent or guardian for patients under 18 years of age, and is the patient him or herself from 18 years of age and up.*

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Relationship to Patient:  Self  Spouse  Parent/Guardian  Other

Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

### HOUSEHOLD AND FINANCIAL INFORMATION

*Please complete the information requested below. Your responses in these two sections help us receive grant funding to provide health care services for our community. In addition, this information may help you qualify to receive additional benefits, such as a Sliding Fee Scale, or discounts on medication or other services.*

*Be assured that your personal, identifiable information is never reported.*

Family Size: \_\_\_\_\_

Monthly Gross Family Income:

- |  |  |
|--|--|
| <input type="checkbox"/> No income       | <input type="checkbox"/> \$2,500-\$3,000               |
| <input type="checkbox"/> \$100-\$500     | <input type="checkbox"/> \$3,500-\$4,000               |
| <input type="checkbox"/> \$500-\$1,000   | <input type="checkbox"/> \$5,500-\$6,000               |
| <input type="checkbox"/> \$1,500-\$2,000 | <input type="checkbox"/> Other (please specify): _____ |

### PATIENT INFORMATION

Farm Worker Status:  Migrant  Seasonal  Not a Farm Worker

Public Housing:  Yes  No

Veteran:  Yes  No If "Yes," Military Discharge:  Yes  No Discharge Date: \_\_\_\_\_

Disabled:  Yes  No

Homeless:  No  Transitional Housing  Homeless Shelter  Street  Other

Refugee Status:  Yes  No If "Yes," what is your country of origin? \_\_\_\_\_

**INSURANCE INFORMATION (Please provide a copy of all insurance cards.)**

Primary Insurance Co.: \_\_\_\_\_ ID#: \_\_\_\_\_

Patient's Relationship to Subscriber/Member:  Self  Spouse  Child  Other: \_\_\_\_\_

**Subscriber/Member:**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex:  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Secondary Insurance Co.: \_\_\_\_\_ ID#: \_\_\_\_\_

Patient's Relationship to Subscriber/Member:  Self  Spouse  Child  Other: \_\_\_\_\_

**Subscriber/Member:**

First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex:  Male  Female

Address: \_\_\_\_\_ City: \_\_\_\_\_ State/Zip: \_\_\_\_\_

**ALTERNATE CONTACT INFORMATION**

**Emergency Contact:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ May we speak to this person about your health?  Yes  No

May we speak to anyone else about your health?  Yes  No If "Yes," Name: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

If you have a caregiver (a family member or helper who regularly looks after you), please list their name and phone number below:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Do you have a current Advance Directive?  Yes  No

If "Yes," please provide us with a copy of your Advance Directive.  
If "No," an Advance Directive Form is available to you upon request.

I decline to provide/discuss Advance Directives:  Yes  No

**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**

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- 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**

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- 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 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: \_\_\_\_\_



**NO-SHOW POLICY (EFFECTIVE 2/5/2018)**

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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**

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Signature of Patient (or Parent/Guardian, if Patient is a minor): \_\_\_\_\_

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT FOR NOTICE OF PRIVACY PRACTICES**

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**Hawai'i Island Community Health Center 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.**

**Hawai'i Island Community Health Center 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.**

**Hawai'i Island Community Health Center'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**

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Signature of Patient (or Authorized Representative): \_\_\_\_\_ Date: \_\_\_\_\_

Print Name of Authorized Representative: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

I have read the Patient's Rights and Responsibilities: \_\_\_\_\_ (Please initial)

This form will be retained in your medical record.