University Health Partners of Hawai`i

The faculty practice of the University of Hawai`i John A. Burns School of Medicine

Department of Internal Medicine
Queen's Physicians Office Building III
550 South Beretania Street, Suite 300 & 510, Honolulu, HI 96813

Patient Information

Name: _____, _____ _____ Sex: M ☐ F ☐ Birth Date: _____
Last First MI

Race/Ethnicity: (Select all that apply) ☐White/Caucasian ☐African American ☐Japanese ☐Chinese ☐Korean ☐Hispanic ☐American Indian ☐Filipino ☐Hawaiian ☐Pacific Islander/Other: _____
Specify

SSN: _____ Referring Doctor: _____

Address: _____ _____ _____ _____
City State Zip Code

Phone: _____ (Home) _____ (Work) _____ (Mobile)

Marital Status (Circle One): Single Married Widow Divorced Other:_____

Email: _____ Interested in HPH MyChart? ☐Yes ☐No

Emergency Contact

Name: _____ Phone No: (____) _____ Relationship: _____

Insurance Information

Primary Insurance: _____ Subscriber/Member No: _____

Subscriber Name: _____, _____ _____ Sex: M F
Last First MI

Birth Date: _____ SSN: _____ Relationship to Subscriber: _____

Secondary Insurance: _____ Subscriber/Member No: _____

Subscriber Name: _____, _____ _____ Sex: M F
Last First MI

Birth Date: _____ SSN: _____ Relationship to Subscriber: _____

Additional Patient Information

Employer: _____ Spouse Name: _____

Address: _____ Spouse Employer: _____

_____ _____
City State Zip Code City State Zip Code

Phone: (_____) _____ Phone: (_____) _____

Occupation: _____ Occupation: _____

ASSIGNMENT OF BENEFITS AND A RELEASE OF INFORMATION TO INSURANCE COMPANY

I hereby authorize University Health Partners (UHP) to its representative, Praxis, to release to my insurance company or its representative any information including the diagnosis and the records or any treatment or examination rendered to me during the periods of such Medical and Surgical care.
I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, including Medicare, Champus, Private Insurance, any other health plan to UHP. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I understand that I will be assessed a $15.00 charge for balance over 90 days. In event of default, I (we) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to affect collection of this note. I hereby authorize said assignee to release all information necessary to secure payment.

Signature: _____ **Date:** _____

University Dept of Medicine Faculty Practice Health History

University Health Partners of Hawai'i

Date _____

Name (Last, First M.I.)	**Sex** ☐ Male ☐ Female	**Birthdate** / /

HEALTH HISTORY: Please check off if you previously had, or presently have, any of the following diseases.

☐ Anemia	☐ Glaucoma	☐ Prostate Trouble
☐ Arthritis	☐ Gout	☐ Rheumatic Fever
☐ Asthma	☐ Heart Trouble	☐ Seizure Disorder
☐ Anxiety/Panic attack	☐ High Blood Pressure	☐ Sexually Transmitted Disease
☐ Bleeding Disorder	☐ High Cholesterol	☐ Skin Disorder
☐ Cancer/Tumor	☐ Kidney Trouble	☐ Stroke
☐ Depression	☐ Liver Disease	☐ Thyroid Trouble
☐ Diabetes	☐ Lung Trouble	☐ Tuberculosis/Positive Skin Test

☐ Other _____

CURRENT MEDICATIONS: List your present medications and dose, *including* supplements and birth control pills. ***NOTE: If you have a separate list, just write "See List".***

☐ No medications ☐ No Over-The-Counter medications/supplements

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

SURGERIES/PROCEDURES: ☐ *No surgeries or procedures*

YEAR	SURGERY / OPERATION	HOSPITAL / CITY & STATE

ALLERGIES: ☐ No known drug allergy

DRUG / INGREDIENT	REACTION

University Dept of Medicine Faculty Practice Health History

University Health Partners of Hawai'i

FAMILY HISTORY: For your family members below, follow the line across the page and fill in their age, health (good/poor) or death. Mark an "X" to indicate any illnesses that they have or ever had.

	Age	Alive	Deceased	Cause of Death	PROBLEMS	Alcohol/Drug	Allergies	Arthritis	Asthma	Blood Disease	Cancer	Colon Cancer	Coronary/Heart Disease	Diabetes	Genetic	Genitourinary (GU)	Gestational Diabetes	Gastrointestinal (GI)	Heart	Hypertension	Lipids	Neurological Disease	Prostate Cancer	Psychiatry	Pulmonary/Lung	Stroke	Thyroid
Mother																											
Father																											
Sister(s):																											
Brother(s):																											
Children:																											

CURRENTLY LIVING: ☐ Alone. ☐ With Family (please specify) _____
☐ Other _____

SUBSTANCE USE:

SMOKING STATUS (choose one):

☐ Never Smoker

☐ Former Smoker: Quit Date: _____, former _____Packs Per Day X ____Years

☐ Current Smoker: _____ Packs Per Day X ____Years

Type: ☐ Cigarette ☐ Pipe ☐ Cigar ☐ E-Cig Other: _____

SMOKELESS TOBACCO STATUS (choose one):

☐ Never

☐ Former: Quit Date: _____ X ____Years

☐ Current: _____ Years

Type: ☐ Snuff ☐ Chew

ALCOHOL CONSUMPTION:

☐ No ☐ Yes, drinks per: Day _____ Week: _____ Month: _____

RECREATIONAL DRUGS:
☐ No ☐ Yes, _____
_____

SOCIAL HISTORY:

RELIGION: ☐ Rather not disclose

Is there any religious preference(s) in your medical care?
☐ No ☐ Yes, _____

EDUCATION:

Do you have any medical background?
☐ No ☐ Yes, _____

REGULAR EXERCISE (type of exercise):
☐ Walking ☐ Swimming ☐ Treadmill ☐ Weight Lifting
☐ Running ☐ Biking ☐ Other: _____

On average, how many minutes per week do you exercise? _____ min/week

SPECIAL DIET: ☐ None ☐ Yes, _____

***IF FEMALE*, please fill out the following information:**

Number of Pregnancies:

☐ Vaginal x _____ ☐ C-section x _____

Living Children:

Abortions:

Miscarriages:

Last Menstrual Period:

Menstrual Cycle Started at Age:

Uterus Removed (Hysterectomy)?:

☐ No ☐ Yes, _____ (month/year)

Authorization for Use and Disclosure of Medical Information

I, _____ Birth Date: _____
(print patient name)

authorize _____
(**NAME OF PREVIOUS PHYSICIAN OR MEDICAL FACILITY THAT WE ARE REQUESTING RECORDS FROM**)

to release copies of the following *medical records pertaining to me:

***Information to be Disclosed**	***Purpose of Use and/or Disclosure**
Date(s) of Service: ☐ Entire Medical Record ☐ Medical Bills ☐ Other (please specify):	☐ Legal purposes ☐ At request of patient ☐ Other:

to be forwarded to:

Physician Name: _____
University, Clinical, Educational & Research Associates for Continuing Medical Care
Medical Specialty Clinic – Internal Medicine
550 S. Beretania Street, Ste. 300
Honolulu, HI 96813
Phone: (808) 536-3773 Fax: (808) 536-3774

____ (initial) **I agree to the release of the following information should it be contained in my medical record: Acquired Immune Deficiency Syndrome (AIDS) or HIV, alcohol and/or drug abuse treatment, or behavioral or mental health services. Unless I specifically agree, this information will not be disclosed.**

**** Unless otherwise revoked, this authorization will expire on the following date or event:**

If a date or event is not specified, this authorization will expire one year from my date of signature below.

A reasonable fee may be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.
This authorization is voluntary. I understand that the above-named health care provider(s) and /or health plan(s) will not condition my treatment, payment, enrollment or eligibility for benefits on the signing of this authorization except as allowed by law.
I understand that the health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under the federal privacy regulations.
I release the above-named provider(s) and/or health plan(s) from all liability and all claims whatsoever pertaining to the disclosure of information as contained in the records released pursuant to this authorization.

* Requestor's signature: _____ * Printed Name: _____
Patient or legally-authorized representative

*Relationship to Patient: _____ * Date: _____

*Items that must be completed for authorization to be valid.

This form has been developed as a collaborative effort among the Hawaii State Bar Association and the Hawaii HIPAA Readiness Collaborative, including The Queen's Medical Center, Hawaii Pacific Health, St. Francis Medical Center and Hawaii Health Systems Corporation.

EXHIBIT "I"

CONSENT FOR TREATMENT

University Clinical, Education &Research Associates dba UHP

677 Ala Moana Boulevard, Suite 1001 • Honolulu, HI 96813-4100 • phone: (808) 469-4900 • fax: (808) 536-7315

Consent for Treatment

I wish to receive medical care and treatment at this University Clinical, Education & Research Associates (UCERA) dba UHP Clinic location. Accordingly, I consent to the procedures that may be performed during this office visit, including emergency treatment. I authorize consent to any of the following: imaging, laboratory procedures, other diagnostic procedures, medical or surgical treatment, or other clinical services that my physician, physician assistant, or nurse practitioner believes are advisable to evaluate or treat me, and to other services rendered under the general and special instructions of my physician.

I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that this office has not made any guarantees to me as to the results of treatments or examinations. I am also aware that I should ask my physician any questions that I may have about my diagnosis, treatment, risks or complications, alternative forms of treatment, and/or anticipated results of treatment.

Disclosure of Information for Payment Purposes

I understand that my medical information will be sent to my insurance carrier for billing purposes for any treatment I may receive at this office including treatment for Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS), mental health diagnoses, and/or drug, alcohol or other substance abuse.

I understand that according to law, I may choose to pay out-of-pocket for certain services if I do not want my health information regarding those services to be provided to my insurance company. I agree to notify this office of my wishes regarding payment before these services are provided. I also understand that if I fail to pay in full for the services, the information will be sent to my insurance company.

Information to Other Providers

I understand that this facility may share my information electronically or on paper with other providers in the course of my treatment, for making arrangements for my continuing care, or upon request when seeking care from other providers. If I prefer that this medical facility not use or share my information, I may submit a written request for consideration per this facility's Notice of Privacy Practices.

Financial Agreement

I understand that I will receive a bill from UCERA. I understand and agree to pay all charges for services rendered and that I am obligated to pay for services in accordance with the regular rates and terms of UCERA. UCERA reserves the right to charge a Late Payment Fee and/or a Returned Check Fee.

If I choose to pay all charges myself, I will notify this office prior to receiving services.

Should the account be referred to an attorney or collection agency for collections, I agree to pay any reasonable attorney's fees, collection expenses and interest at the statutory rate on all delinquent accounts, whether or not the account is referred to a collection agency.

Medicare Coverage

I certify that the information I have given in applying for payment under Medicare is correct. I authorize the Social Security Administration to release information about my Medicare effective dates and Medicare claim number to UCERA. I authorize any holder of medical or related information about me to release any information needed to process this or a related Medicare claim to the Social Security Administration or its intermediaries. I request that payment of benefits be made on my behalf to UCERA for any services provided in this office.

Assignment of Benefits

I hereby authorize assignment of the medical insurance benefits I am due to UCERA for application to bills for medical services and supplies received. I further authorize UCERA to receive direct payment from all such benefit payments. I agree to remain responsible and liable for payments of all amounts due UCERA and not received from my insurance carrier(s). I understand UCERA is submitting claims on my behalf as a courtesy. I shall not revoke this assignment for any reason.

Patient's Rights and Responsibilities

My signature below confirms that I have received the information on my Rights and Responsibilities as a patient.

ACKNOWLEDGEMENT OF RECEIPT OF THIS MEDICAL FACILITY NOTICE OF PRIVACY PRACTICES

I have received a copy of this facility's NOTICE OF PRIVACY PRACTICES.

MINORS OR INCAPACITATED PERSONS- The patient is (please check & complete):

☐ A minor _____ years of age.

☐ Incapacitated and unable to sign for the following reason(s): _____

I have read this consent and I am the patient or the patient's duly authorized representative. On my own behalf (or on behalf of the patient), I accept and agree to be bound by all of these TERMS AND CONDITIONS OF SERVICE until I revoke this authorization to UHP in writing or until one year since last date of service.

_____	_____	_____
Patient or Representative's Signature	Print Name	Date

REPRESENTATIVE: Please describe your authority to act on behalf of the patient: _____

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To the patients of Dr. Takase, Dr. Serrano, and Dr. Hoo:

We would like to inform you of the following:

Phones : There may be times when we are assisting patients on another phone call. If we do not answer please leave a message so we can return your call. Speak clearly and be sure to leave your full name, phone number and doctor that you see. ***You will not be able to leave messages from 4:30pm – 8:00am***.

Co-Pay : Collection of co-payment or co-insurance (depending on your insurance) will be processed at time of check-in. ***Cash, VISA, MasterCard and checks are acceptable forms of payment***.

Prescription Refills : Refills are to be called in **2 weeks prior** to running out medications. Allow our office 48 hours to complete your refill request. Please call the pharmacy to confirm if your prescription is ready for pick-up.

No Show Policy : A patient will be considered a "no show" if an appointment is missed or cancelled with less than 24 hour notice. When this occurs, our practice loses opportunity to care for other patients who wish to be seen. **We reserve the right to dismiss patients from our practice after three (3) no show appointments in a 12-month period**. If you are unable to keep an appointment, please contact us at least 24 hours in advance to reschedule.

_____	_____	_____
Patient Name – Printed	Patient Signature	Date

Date of bith: _____

Privacy Practices Acknowledgement

I have received/reviewed the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____

Signature:_____

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Attention Patients:

We will be using an Automated System for Appointment Reminders

You will be receiving reminders via Email, Text Message, & Automated Phone Messages

Print name: _____

Sign name: _____

Date: _____

If you prefer **NOT** to receive text message reminders, please sign and print below.

Print name: _____

Sign name: _____

Date: _____