MAIKA'I HEALTH CORPORATION

PATIENT REGISTRATION FORM

If completing form by hand, please print

Patient Information

Patient Information:

Last Name: | First Name: | M.I.: | Preferred Name / Nickname:

Legal Sex *(please check one)* :*
☐Female ☐Male ☐Intersex

*Sex assigned at birth. Please note that the name and sex listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence.

Gender Identity:
☐ Female
☐ Male
☐ Transgender Female/Male-to-Female
☐ Transgender Male/Female-to-Male
☐ Other _____
☐ Chose not to disclose

Sexual Orientation:
☐ Bisexual
☐ Lesbian, Gay, or Homosexual
☐ Something else
☐ Straight (not lesbian, gay, or homosexual)
☐ Don't know
☐ Chose not to disclose

Home Address: | City: | State: | Zip Code:

Mailing Address: | City: | State: | Zip Code:

Home Phone: | Cell Phone: | Work Phone:

Preferred method of contact for reminder calls and other electronically generated messages: *(Please select only one option)* ☐ Voice ☐ Text

If voice, please select preferred number: ☐ Home ☐ Cell ☐ Work

Email Address: | Preferred Language:

Do you have reliable access to the Internet from home? ☐ Yes ☐ No ☐ Sometimes_____

Date of Birth: | Social Security #: | Marital Status: ☐ Divorced ☐ Married ☐ Single ☐ Other_____

Emergency Contact Phone #: | Name: | Relationship to Patient:

Responsible Party and Additional Information

Responsible Party - If patient is a minor (under the age of 18), the parent or guardian bringing the patient must be listed as the guarantor:

Last Name: | First Name: | M.I.:

Date of Birth: | Social Security #: | Phone: | Email:

Mailing Address of Person Responsible: | City: | State: | Zip Code:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other:_____

Additional Information (PLEASE FILL OUT ALL SECTIONS BELOW):

Current Living Situation: ☐ Single Family Household ☐ Multi-Generational Household ☐ Homeless ☐ Shelter ☐ Skilled Nursing Facility ☐ Other_____
(check all that apply)

Do you own or rent your current home? ☐ Rent ☐ Own ☐ Other Situation_____

Do you have access to reliable transportation? ☐ Yes ☐ No ☐ Sometimes (please detail)_____

Ethnicity: ☐ Hispanic / Latino ☐ Not Hispanic / Latino

Farmer Status: ☐ N/A ☐ Migrant ☐ Seasonal

Active Military or Veteran: ☐ Yes ☐ No

Race *(pick one below that best describes you)* :

☐ Native Hawaiian ☐ Micronesian ☐ Caucasian ☐ Japanese ☐ Portuguese ☐ African American/Black
☐ Chuukese ☐ Samoan ☐ Chinese ☐ Korean ☐ Puerto Rican ☐ Native American
☐ Guamanian ☐ Tongan ☐ Filipino ☐ Laotian ☐ Vietnamese ☐ Other Asian
☐ Marshallese ☐ Other Pacific Islander (please specify):_____ ☐ Other:_____

Education: ☐ Elementary ☐ High School ☐ Vocational ☐ College ☐ Graduate / Professional

Employer / School Name: ☐ Employed ☐ Unemployed ☐ Student ☐ Full-Time ☐ Part-Time ☐ Casual ☐ Retired

Occupation: | Family Size *(includes yourself, spouse, and children under the age of 18)* :_____ | Family Income: ☐ Monthly ☐ Annual $_____

Insurance Information	Primary Medical Insurance	Secondary Medical Insurance
	Insurance Company Name:	Insurance Company Name:
	Policy Holder Name:	Policy Holder Name:
	Policy Holder's Date of Birth	Policy Holder's Date of Birth:
	Policy Holder's Member ID #:	Policy Holder's Member ID #:
	Patient Relationship to Policy Holder:	Patient Relationship to Policy Holder:

I certify that I have read and agree to Maikaʻi Health Corporation's (MHC) Financial and Consent for Treatment Authorization. I am eligible for the insurance indicated on this form and I understand that payment is my responsibility regardless of insurance coverage. I hereby assign to MHC all money to which I am entitled for medical expenses related to the services performed from time to time by MHC, but not to exceed my indebtedness to MHC. I authorize MHC to release any medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand that failure to pay outstanding balances within 90 days of notification of the amount due will result in submission to an outside collection agency. A $25.00 returned check fee will be charged for checks returned due to insufficient funds. I choose to receive communications from MHC by text or e-mail at the number or address stated above, including but not limited to communications about appointments, feedback, treatment, and payment. I understand that such e-mails and texts may not be secure and there is a risk that they may be read by a third party. Comments submitted on surveys may be anonymously shared on the MHC Public Website.

MEDICARE BENEFICIARIES: I request that payment of authorized Medicare benefits be made to MHC. I authorize any holder of medical information about me to release to CMS and its agents any information needed to determine these benefits

_____ I certify that the information I have provided above is true and correct to the best of my knowledge. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.
Initials

_____ I have reviewed a copy of Maikaʻi Health Corporation's Notice of Privacy Practices.
Initials

_____ I have reviewed a copy of Maikaʻi Health Corporation's Finance and Consent for Treatment Authorization.
Initials

_____ _____
Patient's Signature Date Signed

_____ _____
Guarantor's Signature Date Signed

MAIKA'I HEALTH CORPORATION

PATIENT HEALTH HISTORY

(Confidential)

If completing form by hand, please print

Last Name_____ First Name_____M.I.___Today's Date _____

Gender_____ Age_____ Date of Birth_____ Date of last physical examination_____

mm / dd / yyyy

Name of preferred pharmacy_____ By (Name of Provider)_____

PRIMARY HEALTH CONCERN

What is your biggest health concern that you would like us to address at your first visit?

HEALTH MAINTENANCE

List the most recent date for each of the following that applies to you.

WOMEN ONLY	BOTH MEN AND WOMEN		MEN ONLY
_____ Menstrual period	_____ Cholesterol testing	_____ Pneumonia vaccine	_____ Digital rectal exam
_____ Mammogram	_____ Colonoscopy	_____ Bone Density (DEXA)	_____ PSA (prostate blood test)
_____ Pap smear	_____ Tetanus booster		

CONDITIONS

Check conditions you currently have or have had in the past.

☐ AIDS	☐ Bronchitis	☐ GERD (reflux)	☐ HIV positive	☐ Rhinitis
☐ Alcoholism	☐ Bulimia	☐ Glaucoma	☐ Kidney disease	☐ Sexually transmitted infection
☐ Anemia	☐ CAD / heart disease	☐ Goiter	☐ Liver disease	
☐ Anorexia	☐ Cancer, type_____	☐ Gout	☐ Multiple sclerosis	☐ Stroke
☐ Anxiety	☐ Chemical dependency	☐ Headaches	☐ Pacemaker	☐ Suicide attempt
☐ Arthritis	☐ Depression	☐ Heart attack	☐ Pneumonia	☐ Thyroid problem
☐ Asthma	☐ Diabetes	☐ Hepatitis	☐ Prostate problem	☐ Tuberculosis
☐ Bleeding disorder	☐ Emphysema / COPD	☐ Herpes	☐ Psychiatric care	☐ Ulcer(s)
☐ Breast lump	☐ Epilepsy	☐ High blood pressure	☐ Rheumatic fever	☐ Vaginal infections

☐ Other _____

ALLERGIES?

Check appropriate box below. If yes, please list all known allergies to medications or substances.

Do you have any allergies? ☐ No known allergies. ☐ Yes, I have the following allergies.

Name:_____ Reaction: _____

Name:_____ Reaction: _____

Name:_____ Reaction: _____

Name:_____ Reaction: _____

MEDICATIONS

List all medications, including over-the-counter medications and vitamins. Include dose and frequency.

Name of Medication	Dosage	Frequency

HEALTH HABITS *Check appropriate boxes below and describe.*

Caffeine	☐ None ☐ Yes _____ drinks per _____
Tobacco	☐ None ☐ Yes _____ cigarettes per day ☐ Quit smoking around _____
Alcohol	☐ None ☐ Yes _____ drinks per _____
Drugs	☐ None ☐ Yes
Diet	Describe:
Exercise	Describe:

SURGICAL HISTORY

Year	Hospital / City / State	Type of surgery / complications, if any

OTHER HOSPITALIZATIONS, SERIOUS ILLNESSES, INJURIES

Year	Hospital / City / State	Reason for hospitalization, nature of illness or injury

FAMILY HISTORY *Check if a blood relative has had any of the following.*

FATHER: Living: Age_____ Deceased: Age_____

☐ Alcoholism ☐ Bipolar disorder ☐ Depression ☐ High cholesterol ☐ Osteoporosis
☐ Anemia ☐ Cancer, type_____ ☐ Diabetes ☐ High blood pressure ☐ Stroke
☐ Asthma ☐ COPD / Emphysema ☐ DVT (blood clot) ☐ Kidney disease ☐ Thyroid disorder
☐ Arthritis ☐ Dementia ☐ Heart disease ☐ Migraines
☐ Other:_____

MOTHER: Living: Age_____ Deceased: Age_____

☐ Alcoholism ☐ Bipolar disorder ☐ Depression ☐ High cholesterol ☐ Osteoporosis
☐ Anemia ☐ Cancer, type_____ ☐ Diabetes ☐ High blood pressure ☐ Stroke
☐ Asthma ☐ COPD / Emphysema ☐ DVT (blood clot) ☐ Kidney disease ☐ Thyroid disorder
☐ Arthritis ☐ Dementia ☐ Heart disease ☐ Migraines
☐ Other:_____

SIBLING: ☐ Brother ☐ Sister Living: Age_____ Deceased: Age_____ Medical Conditions: _____
☐ Brother ☐ Sister Living: Age_____ Deceased: Age_____ Medical Conditions: _____
☐ Brother ☐ Sister Living: Age_____ Deceased: Age_____ Medical Conditions: _____
☐ Brother ☐ Sister Living: Age_____ Deceased: Age_____ Medical Conditions: _____

I certify that the information on this form is correct to the best of my knowledge. I will not hold Maikaʻi Health Corporation or any member of its staff responsible for any errors or omissions that I made in the completion of this form.

Patient Signature_____ Date_____

Legal Guardian Signature_____ Date_____
(parent of minor children under age 18 or legal caregiver)

MAIKA'I HEALTH CORPORATION

Financial and Consent for Treatment Authorization Form

Patient: _____ Date of Birth: _____

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize Maika'i Health Corporation (MHC), its medical practices and providers including physicians, technicians, nurses, and other qualified personnel, including appropriately supervised students and residents to perform evaluation and treatment services and procedures as may be necessary in accordance with the judgment of the attending medical practitioner(s). I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations or procedures. TREATMENT OF MINOR CHILDREN: I understand minor children patients must be accompanied by a parent or legal guardian. Charges for services rendered to minor children are the responsibility of the guardian who seeks treatment for the child and are due at time of service(s) regardless of court-ordered responsibility.

PHOTOGRAPHY/VIDEO: I acknowledge that my photograph may be taken for Chart identification and documentation purposes for my electronic health record and is the property MHC unless I withdraw my consent in writing. I consent to videotaping for a telehealth appointment for medical and medical record documentation purposes, provided said photographs or videotapes are maintained and released in accordance with protected health information regulations. I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me comply with this requirement.

INSURANCE AUTHORIZATION AND ASSIGNMENT: I request that payment of authorized medical benefits is made on my behalf directly to the MHC provider of service(s) furnished to me. I authorize MHC to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to MHC. I hereby authorize that photocopies of this form to be valid as the original.

SELF-PAY PATIENTS: I understand if I do not have active coverage or choose not to utilize my insurance benefits, I responsible for all charges occurred at time of service.

PAYMENT GUARANTEE: I understand that I am financially responsible for all charges regardless of third-party involvement. I agree to pay any deductible, co-insurance; copay or any service(s) deemed a "non-covered benefit" by my insurance company. CO-PAYS: I understand that I will be responsible for any co-pays that are due at the time of service.

RESTRICTIVE SERVICE: I understand that all account balances must be in good standing prior to receiving additional services. I understand and agree that my payments will be processed by AkamaiMD, a third-party business associate. I hereby consent to have my payment information collected and stored securely by AkamaiMD. I understand that failure to pay outstanding balances within 90 days of receiving my first statement or fail to comply with other payment arrangements made with MHC's approval, that appropriate collection measures may be initiated. If the debt remains after transfer to a third-party for collection, along with collection costs, attorneys' fees and court fees, the debt may be reported to credit bureaus and your credit rating may be affected. Failure to pay delinquent account balances may result in termination of care from MHC.

ADDITIONAL SERVICE CHARGES: Checks may be processed at time of service, if there are insufficient funds available, I understand I will be responsible for providing an alternate payment for the account amount, plus a $25.00 NSF fee.

NO SHOW/SAME DAY CANCELLATION: I understand that each 'no show' or 'same day cancellation' of a scheduled appointment will result in a fee of $40 per occurrence that I, not my health insurance plan, will be required to pay at the time of my next clinic visit. I understand that a 'no show' means a patient who fails to arrive for a scheduled appointment and a 'same day cancellation' means a patient who cancels an appointment less than 24-hours before their scheduled visit. I acknowledge that should I incur three (3) 'no show' appointments and/or 'same day cancellations' within a 12-month period, I will no longer be permitted to schedule appointments with MHC and will only be seen on a walk-in basis.

ELECTRONIC HEALTH RECORD: I understand the following: Healthcare providers require access to patient medical information whenever or wherever a patient presents for care to assure safety, quality and to coordinate patient care across the provider network, avoiding duplication of services. MHC has a system-wide electronic medical record that is available to caregivers on a "need to know" basis, to share information about patient care provided in the hospital, outpatient or physician office settings. Confidentiality of records including those reflecting treatment for behavioral health issues, HIV/AIDS or drug or alcohol problems is maintained per relevant governmental and regulatory standards. Patient care summaries are automatically sent to designated MHC and other community primary care/family/referring physicians, as well as to physicians who are consulted by the attending physician for coordination of care. MHC and/or the attending physician can furnish and release to federal and state healthcare oversight agencies, or upon written request, to all insurance companies or their representatives any information with respect to treatment of the patient herein named including copies of the medical record.

I give permission to share my electronic medical record among my healthcare providers and obtain medication history through a Provider Health Information Exchange (HIE). I understand that the HIEs allows disclosure of my electronic health record via electronic transfer to other facilities and providers for my treatment purposes. My health information and basic identifying information regarding my visits to MHC may be shared with the HIEs for the purposes of diagnosis and treatment; which includes health information for my continuing care, as well as care I may seek at other locations. MHC will follow state and federal laws regarding the access by medical providers of any sensitive information, such as behavioral health, substance abuse treatment, sexual abuse, genetic test results, HIV/AIDS status and adoption records.

ELECTRONIC PRESCRIBING: I understand that MHC medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my MHC providers and my pharmacy. I have been informed and understand that MHC providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my MHC providers to see this health information.

MEDICATION REFILLS: I understand that it is my responsibility to inform my regular pharmacy and/or MHC if I need to refill medications prior to my next scheduled office visit. I acknowledge that there is no guarantee of refills should I neglect to keep scheduled office visits or fail to reschedule visits due to missed or canceled appointments. Furthermore, I understand that it may take up to three (3) business days for MHC to respond to refill requests.

CONSENT FOR VIRTURAL HEALTH/TELEMEDICINE SERVICES: I hereby consent to engaging in virtual health or telemedicine services, where available, as part of my treatment. I understand that "virtual health" or "telemedicine services" includes the practice of health care delivery, diagnosis, consultation, treatment, transfers of medical data, and education using interactive audio, video, or data communications when the health care provider and patient are not in the same physical location. The interactive electronic systems used for these services will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

I understand that the potential benefits of receiving care in this manner include improved access to care and the ability to obtain the expertise of a distant specialist. The potential risks include problems with information transmittal, including but not limited to poor data transfer which may include a poor video and data quality experience, or lack of access to my complete medical record by the remote physician. I understand that all information, including images, will be part of my medical record available to me if requested and with the same restrictions on dissemination without my consent. I understand I may withdraw my consent at any time.

IMMUNIZATION REGISTRY: I understand that MHC participates in the Hawai‘i Immunization Registry that collects vaccination history and information to serve the public health goal of preventing the spread of vaccine preventable diseases. The registry complies with federal health information privacy laws.

ELECTRONIC COMMUNICATIONS: I hereby consent to provide my email address, telephone number(s), including my wireless telephone number(s), so that representatives from the MHC, its successors or assigns can contact me in any manner including but not limited to by manually placing a call, by using an automatic telephone dialing system or an artificial or prerecorded voice, by texting, or by e-mailing, regarding any matter, including but not limited to my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection matters. This consent includes any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time.

RELEASE OF RESPONSIBILITY FOR PERSONAL VALUABLES: I have been made aware and understand that MHC's clinic(s) and offices provide no facilities for safekeeping of valuables. I do hereby release MHC from any responsibility due to loss or damage of any valuables that I, or anyone accompanying me, may bring to MHC's clinic(s), office or facility.

NOTICE OF PRIVACY PRACTICES: Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have been offered a copy of MHC's Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information, including information generated through use of virtual health or telemedicine services, as described in the Notice of Privacy Practices. This will include all of my protected health information generated during hospitalization and outpatient treatment at the Physician Clinic, including but not limited to treatment for mental health, drug and alcohol abuse, communicable diseases such as HIV/AIDS, developmental disabilities, genetic testing, and other types of treatment received.

I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested.

Signature of Patient or Parent/Legal Guardian/Authorized Representative	Relationship to Patient if Applicable
Witness to Signature	Date/Time of Signing

MAIKA'I HEALTH
CORPORATION

ADMINISTRATIVE SERVICES FEE POLICY

Each day we strive to exceed the expectations of you, our valued patients, through excellent medical care and exceptional service. To assist us in achieving our goal of exceptional service, we have adopted an Administrative Service Fee Policy. The fees list below are per patient, must be paid at the time of service, and are *not billable* to your insurance carrier. However, patients with a flexible spending account may seek reimbursement from their employer as allowed.

Administrative Services

Employee Completed Forms *(Allow 5 business days for completion)* — $25 per form

- Care Home Physical Forms
- Handicap Placard Applications
- FMLA Forms
- Foreign and Domestic Travel Forms
- Other Forms Requiring Completion

The above fees apply to all requests for form completions outside of a scheduled clinic visit. For forms completed as part of a clinic visit, the patient will only be responsible for the cost of dropping off and/or picking up of the completed form(s) to external agencies/organizations.

Medical Records *(Allow 10 business days for completion)*

Hard Copy	$0.20 per page
Digital Copy (via secured electronic transmission or USB)	$20 per record

Requests From: treating physicians, health insurance plans, or court orders

Hard Copy	$1.00 per page
Digital Copy (via secured electronic transmission or USB)	$50 per record

Request to Expedite *(Completed within 3 business days)* — $20 per record
Fee is in addition to the fees listed above for medical records requests.

Fees must be received prior to record delivery. No more than 10 pages may be faxed. *We strongly discourage faxing medical records unless the recipient has a dedicated and personal fax for delivery.*

By my signature below, I acknowledge that I have read and understand this Administrative Services Fee Policy.

_____ _____

Patient or Legal Guardian Signature Date

MAIKA'I HEALTH CORPORATION

PROTECTED HEALTH INFORMATION RELEASE

Please check all that apply and list name(s) of spouse, child(ren), and others involved in your care as applicable.

☐ You have permission to leave information on my answering machine regarding my medical care and test results.

☐ You have my permission to speak with my spouse about my medical care.

☐ You have my permission to talk with my children or other family members involved with my medical care.

☐ Other, please describe: _____

_____

_____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Upon request, I may limit the amount of time that this consent for release of information is valid. I may revoke this authorization, in writing, at any time. I understand that the revocation will not apply to information that has already been released. I understand that authorizing the disclosure of this information is voluntary.

Patient Name: _____ DOB: _____

Signature: _____ Date: _____