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Birth Certificate ☐
Insurance Card ☐
Clinical Intake ☐
Reviewed by ☐

HUI NO KE OLA PONO

Maui's Native Hawaiian Health Care System

Intake Form

Date: ☐

Name: ☐ *Last* ☐ *First* ☐ *Middle Initial* ☐ *(Maiden)*

Social Security No. ☐/☐/☐ Date of Birth: ☐

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

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

Marital Status: ☐ Single ☐ Single with partner ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

MailingAddress: ☐ Zip: ☐
Residence: ☐ Zip: ☐
Phone: (H) ☐ (W) ☐ (Other) ☐

Present living arrangements: (check one)
☐ Own Home ☐ Rent ☐ Live with Ohana ☐ Other: ☐

Ethnicity: (Check all that apply)

☐ Hawaiian ☐ Pacific Islander (Samoan, Tongan, etc.) ☐ Filipino ☐ Portuguese

☐ Asian (Japanese, Chinese, etc.) ☐ White ☐ Hispanic ☐ Black ☐ Native American

☐ Other: ☐

Primary Language:

☐ English ☐ Hawaiian ☐ Other

Other:
Are you an agricultural worker? ☐ Yes ☐ No Is a family member a US Veteran? ☐ Yes ☐ No
Are you a US Veteran? ☐ Yes ☐ No

Financial Information:**

FAMILY INCOME: ☐ Monthly ☐ Yearly Size of Family ☐

Employer: ☐

**Financial information is not required, however if left blank, you are not eligible for sliding fee scales for program costs, full fees will be charged. No Exceptions. "Family Income" means income from all sources in your household.

Insurance Information: *(require copy of all insurance cards)*

☐ None ☐ Medical ☐ Dental ☐ Both

Insurance #1: ☐ ID# ☐

Insured Name: ☐ ☐ ☐
Last *First* *Middle Initial*

Address: ☐ City: ☐ Zip Code: ☐

(If applicable list any additional or supplementary insurance)

☐ None ☐ Medical ☐ Dental ☐ Both

Insurance #2: ☐ ID# ☐

Insured Name: ☐ ☐ ☐
Last *First* *Middle Initial*

Address: ☐ City: ☐ Zip Code: ☐

Authorization and Release:

I authorize Hui No Ke Ola Pono to release to the named insurance company any information necessary to secure insurance payment for billable services. I hereby authorize the physician or dentist to release all information necessary to secure the payment of benefits. *(initials)*

I authorize my insurance company to assign all payments to Hui No Ke Ola Pono. *(initials)*

I understand I will be personally responsible for any charges not paid by my insurance company, with the exception of worker's compensation. *(initials)*

Non-disclosure to Health Insurance:
I do not want my insurance company billed or notified of Hui No Ke Ola Pono's billable services. I understand that by doing this I am obligated to pay any fees for services being rendered to my dependent or myself. *(initials)*

Referral Information:

Who referred you to Hui No Ke Ola Pono? (Check One)

☐ Self ☐ Family ☐ Friend ☐ Doctor ☐ Agency ☐ Other

Reason for referral:

Emergency Contact Information:

List person we may contact in case of emergency
Name: Relationship: Phone:

May we share your health information with your 'Ohana? ☐ Yes, anytime

☐ Yes, if I'm not available ☐ Yes, if I am present in the room ☐ No, never

If "yes", please let us know who we may talk to: ☐ Anyone who tells you they are my 'Ohana. OR

Name: _____ Relationship _____ Phone: _____
Name: _____ Relationship _____ Phone: _____

Can we say Hui No Ke Ola Pono when we write, call or leave a message? ☐ Yes ☐ No

If No, how can we communicate with you?_____

Client Policy and Procedures: *(Please initial)*

_____ I have received a copy of the "HIPAA Notice of Privacy Rights"

_____ I have received a copy of the "Client Rights" handout.

_____ I agree to be included in Hui No Ke Ola Pono's general mailing list.

I hereby request the assistance and/or service from Hui No Ke Ola Pono and authorize and consent to any screening, diagnostic and/or medical/dental treatment under the instruction of the physician and/or dentist caring for my dependent or myself.

_____ _____
Signature Date Signed

_____

Parent or guardian if client is under 18 years old

If guardian is signing, print name:_____