Please check box if you are Native Hawaiian ❑

HUI NO KE OLA PONO

Maui's Native Hawaiian Health Care System

REGISTRATION FORM

PATIENT INFORMATION

Patient Name: _____ **Date of Birth:** _____
Last First MI

Address: _____
Street City State Zip Code

Mailing Address: _____
Street City State Zip Code

Phone Number:
Home: _____
Cell: _____
Work: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced
Agricultural worker: ☐ Yes ☐ No
US Veteran: ☐ Yes ☐ No
Primary Language: ☐ English ☐ Hawaiian ☐ Other_____

Preferred method of contact: ☐ Email: _____ ☐ Phone ☐ Letter

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic ☐ Other/Undetermined ☐ Unspecified ☐ Refused

Race: *(check all that apply)*
☐ Native Hawaiian ☐ Other Pacific Islander ☐ American Indian/Alaska Native ☐ Black/African American
☐ Asian ☐ White ☐ More than one race ☐ Refused/Unreported

Gender Identity:
☐ Male ☐ Female ☐ Transgender Male (Female to Male) ☐ Transgender Female (Male to Female) ☐ Other
☐ Refused

Sexual Orientation:
☐ Straight ☐ Lesbian/Gay ☐ Bisexual ☐ Something else ☐ Don't know ☐ Refused

INSURANCE INFORMATION

Copy of all insurance cards required

☐ **NONE** ☐ *Check if interested in Discounted Fee Application*

☐ **Medical** ☐ **Dental**

Insurance Name: _____ ID/SSN#: _____

Subscriber Name: _____
Last *First* *Middle Initial*

☐ **Medical** ☐ **Dental**

Insurance Name: _____ ID/SSN#: _____

Subscriber Name: _____
Last *First* *Middle Initial*

Authorization and Release:

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

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

Non-disclosure to Health Insurance: _____ *(initial)*
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.

CONFIDENTIALITY/RELEASE OF MEDICAL RECORDS

Confidentiality/Protected Health Information: All patient health information is confidential unless the information is permitted or required to use or disclosed related to the following circumstances: treatment, payment, health care operations, research, organ and tissue donation, as required by law, to avert serious threat to health or safety, military and Veteran's services, Worker's Compensation, public health issues, health oversight, law enforcement, coroners, health examiners, funeral directors, National Security and Intelligence activities and inmates. Patients may give or be asked to give authorization for release of information under other circumstances.

Signed: _____ Date: _____

ACKNOWLEDGEMENTS

I have received or been offered a copy of Hui No Ke Ola Pono's:

_____ *(initial)* HIPAA Notice of Privacy Rights

_____ *(initial)* Client's Rights

AUTHORIZATION TO TREAT

I hereby authorize the staff at Hui No Ke Ola Pono to perform any and all diagnoses, procedures, and/or treatment as deemed necessary for the care and treatment of the patient for the condition for which I or members of my family have sought care. This authorization is effective today and will remain in effect until: the parent/guardian releases the patient from our care; the provider withdraws from care; or the patient releases him or herself from our care.

Signed: _____ Date: _____

EMERGENCY CONTACT INFORMATION		
Name:	Relationship:	Phone:

Who referred you to Hui No Ke Ola Pono? ☐ Self ☐ Family ☐Friend ☐ Doctor ☐ Agency ☐ Other: _____