Nada, Ono, Ka'anehe & Solomon, LLP. Today's Date: ____________________

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)	ADDRESS (please include apartment/unit number, if any)		
CITY, STATE, ZIP	PRIMARY PHONE	CELL PHONE	WORK PHONE

BIRTH DATE	SSN	SEX: ❑ MALE ❑ FEMALE	EMAIL
ETHNICITY ❑ HISPANIC or LATINO ❑ NON-HISPANIC or LATINO	RACE	PRIMARY LANGUAGE	MARITAL STATUS: ❑ SINGLE ❑ MARRIED ❑ DIVORCED ❑ WIDOWED ❑ SEPARATED

INSURANCE / RESPONSIBLE PARTY INFORMATION

PRIMARY INSURANCE	ID NUMBER		GROUP NUMBER
SUBSCRIBER'S NAME	RELATIONSHIP TO PATIENT: ❑ SELF ❑ SPOUSE ❑ PARENT	SSN	BIRTH DATE
SECONDARY INSURANCE	ID NUMBER		GROUP NUMBER
SUBSCRIBER'S NAME	RELATIONSHIP TO PATIENT: ❑ SELF ❑ SPOUSE ❑ PARENT	SSN	BIRTH DATE

PCP (PRIMARY CARE PHYSICIAN)	REFERRING DOCTOR	
IN CASE OF EMERGENCY CONTACT	RELATIONSHIP TO PATIENT	PHONE NUMBER

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

PRINT NAME OF PATIENT	SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE

AUTHORIZATION TO RELEASE HEALTH INFORMATION TO:

NAME(S)	ADDRESS		
CITY, STATE	ZIP	HOME PHONE	DAYTIME PHONE
DATES OF SERVICE FROM: TO:	AUTHORIZATION EXPIRES (UNLESS OTHERWISE NOTED THIS AUTHORIZATION WILL REMAIN IN EFFECT ONE YEAR FROM THE DATE SIGNED) ❑ NEVER DATE:		

Release the following information:

❑ **All Records** ❑ **Chart Notes** ❑ **Radiology Reports** ❑ **Operative Reports** ❑ **History & Physicals**

RELEASE OF INFORMATION

I understand that:

- Once "<u>this facility</u>" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- My records are protected and cannot be disclosed without written permission
- This Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

PRINT NAME OF PATIENT	SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):	

DO YOU HAVE AN ADVANCED CARE DIRECTIVE? ❑ **YES** ❑ **NO**

Nada, Ono, Ka'anehe & Solomon, LLP Today's Date: ____________________

PATIENT MEDICAL HISTORY

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL)

PREFERRED PHARMACY:

PREFERRED LABORATORY: ❑ Diagnostic Lab (DLS) ❑ Clinical Lab (CLH) ❑ Straub ❑ Other:

IMMUNIZATIONS – Have you had any of the following:

FLU VACCINE? ❑ YES ❑ NO IF YES, WHERE AND WHEN: ____________________

PNEUMONIA VACCINE? ❑ YES ❑ NO IF YES, WHERE AND WHEN: ____________________

ALLERGIES

❑ NONE/No Known Allergies ❑ Adhesive Tape ❑ Anesthesia ❑ Aspirin ❑ Codeine
❑ Dairy Products ❑ Iodine/Contrast Dye ❑ Latex ❑ Morphine ❑ Penicillin
❑ Sulfa Drugs ❑ Shellfish/Seafood ❑ **OTHER:**

FAMILY HISTORY – Please indicate if any of your immediate relatives have had any of the following by placing an X in the appropriate box.

	MOTHER	FATHER	SIBLING (Brother/Sister)	CHILD
Kidney Disease				
Diabetes				
High Blood Pressure				
Heart Disease				
Cancer				
Stroke				
Thyroid Disorder				

SOCIAL HISTORY

Marital status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Employment Status : ❑ Employed (full-time or part-time) ❑ Retired ❑ Unemployed ❑ Disabled ❑ Student

Current/Former Occupation: ____________________ Current/Former: Employer:____________________

Have you used any of the following substances?	Substance	Current User?	Former User?	How often?	How Long? (years)	If stopped, when? (Year)
	TOBACCO	❑ Yes ❑ No	❑ Yes ❑ No			
	ALCOHOL	❑ Yes ❑ No	❑ Yes ❑ No			
	ILLICIT DRUGS	❑ Yes ❑ No	❑ Yes ❑ No			
	Types:	❑ Marijuana ❑ Meth ❑ Cocaine ❑ Heroin ❑ Ecstacy ❑ LSD ❑ Other:____________				

Medical History: Have you ever suffered from any of the following?

❑ NONE of the problems listed

❑ AIDS or HIV	❑ Diabetes	❑ High Cholesterol	❑ Psychiatric Disorder
❑ Anemia	❑ Edema	❑ Hives or eczema	❑ Rheumatic Fever
❑ Arthritis	❑ Diphtheria	❑ Infectious Mono	❑ Scarlet Fever
❑ Asthma	❑ Epilepsy	❑ Kidney Disease	❑ Shortness of Breath
❑ Back Trouble	❑ Glaucoma	❑ Low Blood Pressure	❑ Small Pox
❑ Bladder Infection –UTI	❑ Gout	❑ Measles	❑ Snoring
❑ Bleeding Tendency	❑ Heart Disease	❑ Migraine Headaches	❑ Stroke
❑ Bronchitis	❑ Hemorrhoids	❑ Mitral Valve Prolapse	❑ Tuberculosis
❑ Cancer	❑ Hepatitis	❑ Mumps	❑ Ulcer
❑ Chicken Pox	❑ Hernia	❑ Pneumonia	❑ Venereal Disease
❑ Depression	❑ High Blood Pressure	❑ Polio	❑ Whooping Cough

MEDICATION LIST

Please list all medications prescribed by your physician(s), including over-the-counter and supplements. Also include any ointments, injections, liquids, inhalers and any medications taken on occasion.

Patient Name: ____ Date Of Birth: __________________ Date Updated: _________________

Name of medication	**Dosage** (mg, mL, units, etc.)	**Frequency** (How often?)	**Reason for taking**	**Directions**	**Start & stop date**	**Taking as directed?** (Yes or No)	**Prescribing doctor**

Have you recently been hospitalized? YES or NO (if yes, explain): ____

Have you recently undergone any surgeries? YES or NO (if yes, explain): ____

Have you recently fallen? YES or NO (if yes, explain): ____

HAWAII KIDNEY SPECIALISTS

NADA - ONO - KAANEHE - SOLOMON - HAYASHI

AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL RECORDS FROM MEDICAL PROVIDERS

I hereby authorize HAWAII KIDNEY SPECIALISTS to obtain any and all medical records concerning my care from any physician, hospital, or other healthcare professional that has provided medical care to me in the past.

I also authorize HAWAII KIDNEY SPECIALISTS to release any and all medical records concerning my care to any physician, hospital, or other healthcare professional providing care to me at any time. Additionally, I authorize the practice to release any and all medical records concerning my care to Medicare, Medicaid, any insurance company, third-party administrator, or managed Care Company.

______________________________ ______________________________

Patient Signature **Date Signed**

______________________________ ______________________________

Printed Name **Date of Birth**

AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with the federal government's privacy rule implementation of the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of HAWAII KIDNEY SPECIALISTS to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode, or if you're unable to give your authorization due to severity of your medical condition, the law stipulates that these rules may be waived.

***A reasonable fee may be charged for duplication of records.**
An estimate of those charges will be provided upon request prior to duplication.

_______ **I do not** authorize the practice to release any information concerning my medical care to any individual except as set forth above.

_______ **I authorize** the practice to release any and all information concerning my medical care to the following individual(s):

______________________________________ ______________________________ ______________________

Name **Relationship to Patient** **Phone Number**

______________________________ ______________________________

Patient Signature **Date Signed**

______________________________ ______________________________

Printed Name **Date of Birth**

PATIENT FINANCIAL POLICY

Thank you for choosing HAWAII KIDNEY SPECIALISTS as your Nephrology healthcare provider.
The following is a statement of our payment policy. This payment policy applies to all services provided by HAWAII KIDNEY SPECIALISTS, regardless of location.

Insurance Coverage – We will bill your health insurance carrier for services rendered by our providers, but it is your responsibility to make sure that we have your most current insurance information. If you change or add an insurance policy, you must make our staff aware and present a new insurance card prior to your appointment. Any balances not paid by your insurance carrier are your responsibility, and payment is due upon receipt of a "Billing Statement" or your next office visit, whichever occurs first.

Copays – We have a contractual obligation (with your insurance company) to collect your copay. We will collect it at the time of service. Our office does not bill copays. **Copays are the patient's responsibility and are due at the time of service**. We are considered specialty care by insurance carriers. If your insurance carrier has a specific copay amount for specialty care, you will be expected to pay this amount at the time of service. We cannot waive copays, deductibles, or coinsurance for non-covered services defined as patient responsibility under the terms of our contract with various health plans.

For our patients with no Medical Insurance Benefits – If you do not have group or individual medical insurance, payment for all services is expected at the time of your visit. Please let us know if you are having difficulty paying your account as we may be able to help by setting up a payment plan based on your financial needs.

Accepted Forms of Payment – We accept payment by cash, check, Visa, MasterCard, and Discover.

Unpaid Accounts – In the event that you do not satisfy your account balance on a timely basis (defined as making a regular payment each month), we may elect to send your account to an outside collection agency.

Returned Check Fee – It is the policy of Hawaii Kidney Specialists to charge $10 to patients whose checks are returned by our bank for non-sufficient funds.

I have read and agree to the above Payment Policy. I understand that charges not covered by my insurance company, as well as applicable copay and deductibles are my responsibility.

______________________	______________________	______________
Signature of Patient	**Patient Name (Please Print)**	**Date**

MEDICARE EXTENDED AUTHORIZATION – "SIGNATURE ON FILE": I request that payment of authorized Medicare benefits be made either to me or, on my behalf, to HAWAII KIDNEY SPECIALISTS for any services furnished to me by members of that and its agents, any information needed to determine these benefits or benefits payable for the related services.

Signed ________________________________ **Date** ______________________

COMMERCIAL INSURANCE ASSIGNMENT OF BENEFITS: I request that payment of authorized Commercial Insurance benefits, both primary and secondary, be made on my benefit to HAWAII KIDNEY SPECIALISTS for any services furnished to me by members of that professional association. I authorize any holder of medical information about me to release to the above-mentioned insurance carrier, any information needed to determine these benefits payable or benefits payable for related services.

Signed ________________________________ **Date** ______________________