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

HAWAII KIDNEY SPECIALISTS

NADA - ONO - KAANEHE - SOLOMON - HAYASHI

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** _____

Aaron K. Nada, M.D.
David D. Ono, M.D.
Leilani Ka`anehe, M.D.
Noah M. Solomon, M.D.
Rick Y. Hayashi, M.D.

HAWAII KIDNEY SPECIALISTS
NADA - ONO - KAANEHE - SOLOMON - HAYASHI

Internal Medicine & Nephrology
Liliha Professional Building
1520 Liliha Street, Suite 601
Honolulu, HI 96817-3564
Telephone: (808) 523-0445
Fax: (808) 356-3380

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, I acknowledge receipt of the Notice of Privacy Practices from the office of Nada, Ono, Ka`anehe, Solomon, & Hayashi, LLP. I understand that this office may use and disclose necessary personal health information (for example: my name, address, medical examination information, ect.) to another party to permit the office to perform its administrative duties, providing me with medical care services, process my benefit claims, and communicate with me regarding medical care services provided by this office.

I can be assured that this location does not sell my personal health information of any kind to a third party for such party's own use. I authorize the office to submit my health benefit claims to my plan sponsor or health plan to receive reimbursement directly for the medical services that I have received from this office. The Notice of Privacy Practices is subject to change. If the Notice is changed, you may obtain a revised copy on request from our staff.

Do you want to designate a family member or other individual with whom the provider may discuss your medical condition? If yes, whom?

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of the individual(s) you authorize our office to discuss your care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

	Name	Relationship	Contact Number
1.			
2.			
3.			

Patient Signature _____ **Date Signed** _____

Printed Name _____ **Date of Birth** _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

☐ The patient refused to sign.

☐ Due to an emergency situation it was not possible to obtain an acknowledgement.

☐ We weren't able to communicate with the patient.

☐ Other *(Please provide specific details)*

_____

_____

_____ _____

Employee signature Date

Aaron K. Nada, M.D.
David D. Ono, M.D.
Leilani Ka`anehe, M.D.
Noah M. Solomon, M.D.
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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, HOW YOU CAN GET ACCESS TO THIS INFORMATION, YOUR RIGHTS CONCERNING YOUR HEALTH INFORMATION AND OUR RESPONSIBILITIES TO PROTECT YOUR HEALTH INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by State and Federal laws to maintain the privacy of health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information.

If you have any questions about his notice or you would like to request a copy of our Privacy Notice at any time by contacting our Privacy Officer. Information on contacting us can be found at the end of this Notice.

We will keep your health information confidential, using it only for the following purposes:

Treatment: We use medical information about you to provide your medical care. We may disclose your protected health information (PHI) including electronic protected health information (ePHI) with other health care providers, business associates and their subcontractors or individuals who are involved in your treatment, billing, administrative support, medical review, legal services and audits, and to operate this medical practice. We have written contracts with each of these business associates and subcontractors that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information.. We have established "minimum necessary" or "need to know" standards that limit various staff members' access to your health information according to their primary job functions.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations, collections or other third parties that may be responsible for such costs, such as family members.

Disclosure: We may disclose and/or share protected health information (PHI) including electronic disclosure with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so. As of March 26, 2013 immunization records for students may be released without an authorization (as long as the PHI disclosed is limited to proof of immunization). If an individual is deceased we may disclose PHI to a family member or individual involved in care or payment prior to death. Genetic Information Nondiscrimination Act (GINA) prohibits health plans from using or disclosing genetic information for underwriting purposes. Uses and disclosures not described in this notice will be made only with your signed authorization.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures" of your protected information if the disclosure was made for purposes other than providing services, payment, and or business operations. In light of the increasing use of Electronic Medical Record technology (EMR), the HITECH Act allows you the right to request a copy of your health information in electronic form if we store your information electronically. Disclosures can be made available for a period of 6 years prior to your request and for electronic health information 3 years prior to the date on which the accounting is requested. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. To request this list or accounting of disclosures, you must submit your request in writing to our Privacy Officer. We may charge a reasonable, cost based fee.

Right to Request Restriction of PHI: If you pay in full out of pocket for your treatment, you can instruct us not to share information about your treatment with your health plan; if the request is not required by law. You have the right to request restrictions on certain uses and disclosures of your health information by written request specifying that information you want to limit, and what limitations on our use or disclosure of that information

Non-routine Disclosures: You have the right to request a list of non-routine disclosures we have made of your health care information. We will include all disclosures except for those about treatment, payment, and healthcare operations, and certain other disclosures (such as any you asked us to make) going back 6 years.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical staff, insurance operations, health care clearinghouses and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.)
We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Aaron K. Nada, M.D.
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National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure, and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so. Effective March 26, 2013, we are required to obtain an authorization for marketing purposes if communication about a product or service is provided and we receive financial remuneration (getting paid in exchange for making the communication). No authorization is required if communication is made face-to-face or for promotional gifts.

Sale of PHI: We will not disclose PHI without your prior written authorization if it constitutes remuneration (getting paid in exchange for the PHI). **"**Sale of PHI" does not include disclosures for public health, certain research purposes, treatment and payment, and for any other purpose permitted by the Privacy Rule, where the only remuneration received is "a reasonable cost-based fee" to cover the cost to prepare and transmit the PHI for such purpose or a fee otherwise expressly permitted by law.

Change of Ownership: In the event that this medical practice is sold or merged with another ortanization, your health information/record will become the property of the new owner, although you maintain the right to request that copies of your health information be transwered to another physician or medical group.

Appointment Reminders: We may use and disclose medical information to contact and remind you about your appointments, recommended services, or treatments. If you are not available, we may leave this information on your answering machine or in a message left with the person answering the phone.

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) We will provide access to health information in a form / format requested by you. There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our office for a copy of the request form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. If a copy is requested, we may charge a reasonable and cost-based fee. If you want the copies mailed to you, postage will also be charged. Access to your health information in electronic form if (readily producible) may be obtained with your request. If for some reason we aren't capable of an electronic format, a readable hardcopy will be provided. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact our Privacy Officer for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Breach Notification Requirements: It is presumed that any acquisition, access, use or disclosure of PHI not permitted under HIPAA regulations is a breach. We are required to complete a risk assessment, and if necessary, inform HHS and take any other steps required by law. You will be notified of the situation and any steps you should take to protect yourself against harm due to the breach.

Changes to this Notice of Privacy Practices: We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted at our reception desk and a copy will be available at each appointment.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. **HOW TO CONTACT US:**

Practice Name: Nada, Ono, Ka`anehe, Solomon, & Hayashi, LLP Privacy Officer: Meredith Loo

Telephone: (808) 523-0445 Fax: (808) 356-3380

Address: 1520 Liliha Street, Suite 601 City, State: Honolulu, HI 96817