Hawaii Kidney Specialists

Ph: 808-523-0445
Fax: 808-356-3380

Pt id# _____

Patient Information

Patient's Name (First, Middle, Last): _____

Address: _____

City: _____ State: _____ Zip Code: _____ Email: _____

Main Contact#: _____ Alternate#: _____ Work#: _____

Date of Birth: ____/____/____ Sex: Male Female Social Security #: _____

Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed Occupation: _____

Primary Care Physician: _____ Telephone #: _____

Spouse's Name: _____ Telephone#: _____

Emergency Contact: _____ Telephone #: _____

Other Patient Information

Which racial category does the patient most closely identify with?

○ African American ○ Asian ○ Caucasian ○ Hispanic

○ Native American ○ Native Hawaiian ○ Pacific Islander ○ Other: _____ (Please Specify)

Ethnicity: What is the patient's ethnicity? ○ Hispanic or Latino ○ Not Hispanic or Latino

What is the patient's language of preference? ○ English ○ Spanish ○ Other: _____ Please Specify)

Insurance Information

PCP (Primary care physician) _____ Referring Physician _____

Primary Insurance: _____ Policy/ID# _____

Name of Policy Holder: _____ DOB: ____/____/____ Group/Acct #: _____

Secondary Insurance: _____ Policy/ID# _____

Name of Policy Holder: _____ DOB: ____/____/____ Group/Acct #: _____

Preferred laboratory:

☐Diagnostic Lab (DLS) ☐ Clincial Lab (CLH) ☐Straub ☐Other: _____

Preferred Pharmacy:

Name _____ Address _____ Ph# _____

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Patient Acknowledgements and Consents

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION

In consideration of services rendered, I hereby assign to Hawaii Kidney Specialists, and/or any physician who has treated me, all the rights, title, and interest in any payment due for services described herein as provided in the policy, or policies, of insurance. I agree to pay the charges of Hawaii Kidney Specialists, which are greater than the amount paid by the insurance company or companies. I understand that it is my responsibility to know the benefits of my insurance plan and whether or not the services I am to receive are covered or not. I understand that I am, financially responsible for all the services rendered to me. **I understand and agree to pay all co-pays, co- insurance and/or deductibles at the time of service rendered**.
I authorize Hawaii Kidney Specialists, and its billing agents to release pertinent medical information to my insurance company or companies when requested, or to facilitate payment of a claim.

_____ _____ _____
Printed Name Signature Date

Cancellation/No Show Policy

Hawaii Kidney Specialists requires a minimum of 24 hours notice for appointment cancellation except in the case of Emergency. This allows us to accommodate another patient.

Excessive cancellations and/or no shows may result in the practice discharging you from care.

I have read and understand the above policy

_____ _____ _____
Printed Name Signature Date

Labs prior to visit policy

Most return and follow-up visits will require the patient to have had labs drawn and resulted prior to the visit. We will send orders to the requested lab and provide a paper copy of the orders for you to take with you. It is your responsibility to make sure all labs are drawn prior to your visit. Failure to have labwork done as requested may result in the appointment being rescheduled

I have read and understand the above policy

_____ _____ _____
Printed Name Signature Date

Pt id# _____

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Patient Acknowledgements and Consents

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**You May Refuse to Sign this Acknowledgement*

I understand that as part of the provision of healthcare services, Hawaii Kidney Specialists originates records and maintains health information about me describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this health information may be used or disclosed by Hawaii Kidney Specialists for treatment, payment, and health care operations. For example, my health information serves as:

- A basis for planning my care and treatment;
- A means of communication among other health professionals who contribute to my care;
- A source of information for applying my diagnosis and surgical information to my bill;
- A means by which a third-party payor can verify that services billed were actually provided;

I acknowledge that I have been provided with Hawaii Kidney Specialists' Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that Hawaii Kidney Specialists reserves the right to change its Notice of Privacy Practices at any time and that I will be provided a copy of the revised Notice of Privacy Practices.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations, and that Hawaii Kidney Specialists is not required to agree to the restrictions requested but if it does, it is bound by such restrictions.

I understand that I may revoke this consent in writing, except to the extent that Hawaii Kidney Specialists has already taken action in reliance thereon.

By signing this form, I consent to Hawaii Kidney Specialists use and disclosure of my health information for treatment, payment, and health care operations.

☐ I request the following restrictions to the use or disclosure of my health information:

_____

_____

_____

☐ Restrictions Accepted ☐ Restrictions Denied

Print Patient Name _____ DOB _____ Last 4 SS# _____

Signature of Patient/Patient Representative _____ Date _____

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Patient Acknowledgements and Consents

CONSENT FOR MEDICAL CARE AND TREATMENT

I understand that I may have a medical condition that could require examination, diagnosis and treatment and other medical services which may include x-rays, laboratory procedures, tests and medications. I do hereby voluntarily consent to such examination, diagnosis, treatment, and other medical services, and procedures that may be recommended under the general and specific instructions of the physicians of Hawaii Kidney Specialists, their assistants, nurses or designees. I acknowledge that the practice of medicine is not an exact science and that the physicians of Hawaii Kidney Specialists have made no guarantees to me as to the result of examination, diagnosis, treatment or other medical services.

☐ I consent ☐ I do not consent

CONSENT FOR ALTERNATE COMMUNICATION

Hawaii Kidney Specialists recognizes the importance and significance of maintaining confidentiality of information regarding a patient's medical condition. We also want to provide our patients timely communication as to laboratory/diagnostic test results and other patient medical information. We understand that because of the patient's schedules and our office schedules, personal communication may sometimes be difficult. Hawaii Kidney Specialists' policy is not to leave messages regarding sensitive medical information with unauthorized third parties. However, acknowledging that it may be difficult for the physician/physician's staff to personally communicate with the patient regarding laboratory/diagnostic test results, or patient medical information, it is the policy of Hawaii Kidney Specialists to leave such information on the patient's phone messaging system unless you indicate that you do not consent to leaving such messages on your phone system.

☐ I consent ☐ I do not consent

If the physician/physician's staff cannot reach the patient at the home, cell or business telephone, it is the policy of Hawaii Kidney Specialists that a message will be left with the person that answers the telephone to advise the patient to return the phone call unless you indicate you do not consent.

☐ I consent ☐ I do not consent

It is the policy of Hawaii Kidney Specialists to send appointment reminders to our patients, either by phone, e-mail, text, or reminder cards unless you indicate you do not consent.

☐ I consent ☐ I do not consent

All of the foregoing consents are continuing in nature during the entire course of my care unless specifically revoked by me.

Print Name of Patient_____ DOB_____ Last 4 SS#_____

Signature of Patient _____ Date _____

(Any individual *consent or this entire consent can be revoked at any time upon receipt of your written request)*

Pt id# _____

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PRIVACY & SECURITY RELEASE

As a covered of the Health Insurance Portability and Accountability Act (HIPPA) Hawaii Kidney Specialists, and its business associates are protecting the privacy and security of your medical information. As such we do not release any information without your approval. This includes, but is not limited to medical and financial information. Please list any persons below, whom you are giving permission to have Hawaii Kidney Specialists, or its business associates, release information in regards to your care or billing.

_____ _____( ) Medical ( ) Financial
Person's Name Relationship

_____ _____ ( ) Medical ( ) Financial
Person's Name Relationship

_____ _____ ( ) Medical ( ) Financial
Person's Name Relationship

_____ _____ _____
Printed Name **Signature** **Date**

In case of Emergency Contact

Name _____ Relationship to Patient _____PH # _____

Do you have and Advanced Care Directive ☐ Yes ☐ No