



PATIENT INFORMATION			
LEGAL LAST NAME:		FIRST NAME:	DATE OF BIRTH:
PREFERRED NAME:		LEGAL SEX (check ONE)* <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE <small>* Sex assigned at birth (Male and Female). Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence</small>	
HOME ADDRESS:		CITY:	STATE: ZIP:
MAILING ADDRESS:		CITY:	STATE: ZIP:
MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
NEED INTERPRETER: <input type="checkbox"/> Yes <input type="checkbox"/> No		PREFERRED LANGUAGE: <input type="checkbox"/> English <input type="checkbox"/> Other:	
<small>(check ONE to indicate preferred contact method)</small>	<input type="checkbox"/> HOME PHONE:		<input type="checkbox"/> CELL PHONE:
	<input type="checkbox"/> DAY/WORK PHONE:		<input type="checkbox"/> EMAIL:
<i>Patient Portal is WCCHC's technology that allows you to schedule/view appointments, request medication refills and see lab results, communicate with your health care team, ask questions about your bill and request your health record.</i>			
Are you enrolled in Patient Portal? <input type="checkbox"/> Yes <input type="checkbox"/> No		If "No," do you want assistance to enroll? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>An Advance Directive is a form stating how much medical care you want to receive or designating someone to make medical decisions in the event you are not able to respond.</i>			
Do you have an Advance Directive? <input type="checkbox"/> Yes <input type="checkbox"/> No		If "No," do you want assistance to create? <input type="checkbox"/> Yes <input type="checkbox"/> No	
HOUSING STATUS: <input type="checkbox"/> Not Homeless <input type="checkbox"/> Homeless:		<input type="checkbox"/> Doubling Up	<input type="checkbox"/> Shelter
		<input type="checkbox"/> Transitional	<input type="checkbox"/> Unreported
		<input type="checkbox"/> Street, Beach, etc.	
FARMER STATUS: <input type="checkbox"/> Migrant <input type="checkbox"/> Seasonal <input type="checkbox"/> N/A		ACTIVE MILITARY OR VETERAN: <input type="checkbox"/> Yes <input type="checkbox"/> No	
ETHNICITY: <input type="checkbox"/> Cuban <input type="checkbox"/> Mexican, Mexican American, Chicano <input type="checkbox"/> Puerto Rican <input type="checkbox"/> Hispanic/Latino origin, combo unknown <input type="checkbox"/> Not Hispanic or Latino			
RACE: <small>(pick ONE that best describes you)</small>	<input type="checkbox"/> African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Cambodian <input type="checkbox"/> Caucasian <input type="checkbox"/> Chinese <input type="checkbox"/> Filipino <input type="checkbox"/> Guamanian <input type="checkbox"/> Hawaiian/Part-Hawaiian <input type="checkbox"/> Indian/Asian <input type="checkbox"/> Japanese <input type="checkbox"/> Korean <input type="checkbox"/> Laotian <input type="checkbox"/> Marshallese <input type="checkbox"/> Micronesian <input type="checkbox"/> Samoan <input type="checkbox"/> Thai <input type="checkbox"/> Tongan <input type="checkbox"/> Vietnamese <input type="checkbox"/> Other Asian <input type="checkbox"/> Other Pacific Islander (not Hawaiian)		
GUARANTOR INFORMATION			
RELATIONSHIP OF GUARANTOR TO PATIENT: <input type="checkbox"/> Spouse <input type="checkbox"/> Parent <input type="checkbox"/> Other:			
LEGAL LAST NAME:		LEGAL FIRST NAME:	M.I.:
PREFERRED NAME:		DATE OF BIRTH:	
HOME ADDRESS:		CITY:	STATE: ZIP:
MARITAL STATUS: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
NEED INTERPRETER: <input type="checkbox"/> Yes <input type="checkbox"/> No		PREFERRED LANGUAGE: <input type="checkbox"/> English <input type="checkbox"/> Other:	
<small>(check ONE to indicate preferred contact method)</small>	<input type="checkbox"/> HOME PHONE:		<input type="checkbox"/> CELL PHONE:
	<input type="checkbox"/> DAY/WORK PHONE:		<input type="checkbox"/> EMAIL:



PATIENT REGISTRATION: INSURANCE

PATIENT NAME:

MRN:

PRIMARY MEDICAL INSURANCE INFORMATION

None

PATIENT'S RELATIONSHIP
TO THE INSURED:

Self

Parent

Step-Child

Spouse

Child

Other:

POLICY HOLDER NAME:

DATE OF BIRTH:

SEX: Male Female

PLAN NAME:

POLICY/SUBSCRIBER #:

GROUP #:

EFF. DATE:

EXP. DATE:

HOME ADDRESS:

CITY:

STATE:

ZIP:

HOME PHONE:

CELL PHONE:

WORK PHONE:

SECONDARY MEDICAL INSURANCE INFORMATION

None

PATIENT'S RELATIONSHIP
TO THE INSURED:

Self

Parent

Step-Child

Spouse

Child

Other:

POLICY HOLDER NAME:

DATE OF BIRTH:

SEX: Male Female

PLAN NAME:

POLICY/SUBSCRIBER #:

GROUP #:

EFF. DATE:

EXP. DATE:

HOME ADDRESS:

CITY:

STATE:

ZIP:

HOME PHONE:

CELL PHONE:

WORK PHONE:

PRIMARY DENTAL INSURANCE INFORMATION

None

PATIENT'S RELATIONSHIP
TO THE INSURED:

Self

Parent

Step-Child

Spouse

Child

Other:

POLICY HOLDER NAME:

DATE OF BIRTH:

SEX: Male Female

PLAN NAME:

POLICY/SUBSCRIBER #:

GROUP #:

EFF. DATE:

EXP. DATE:

HOME ADDRESS:

CITY:

STATE:

ZIP:

HOME PHONE:

CELL PHONE:

WORK PHONE:

SECONDARY DENTAL INSURANCE INFORMATION

None

PATIENT'S RELATIONSHIP
TO THE INSURED:

Self

Parent

Step-Child

Spouse

Child

Other:

POLICY HOLDER NAME:

DATE OF BIRTH:

SEX: Male Female

PLAN NAME:

POLICY/SUBSCRIBER #:

GROUP #:

EFF. DATE:

EXP. DATE:

HOME ADDRESS:

CITY:

STATE:

ZIP:

HOME PHONE:

CELL PHONE:

WORK PHONE:



CONSENT FOR TREATMENT & COMMUNICATIONS FORM

PATIENT NAME:

MRN:

I understand that as part of my health care, **Waianae Coast Comprehensive Health Center (WCCHC)** (includes James and Abigail Campbell Nanakuli Clinic, Kapolei Health Care Center, Waianae Vision Care, Waiola Clinic and Waipahu Family Health Center) originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

1. A basis for planning my care and treatment
2. A means of communication among the many health professionals who contribute to my care
3. A source for applying my diagnosis and surgical information to my bill in order for WCCHC to receive payment
4. A means by which a third party payer can verify that services billed were actually provided
5. A tool for health care operations, i.e. assessing quality and reviewing competence of health care professionals

By initialing in the section below, I acknowledge and understand:

 <i>(Patient Initials)</i>	That I have been offered a copy of WCCHC's Notice of Privacy Practices and Patient Rights & Responsibilities that provides a description of information uses and disclosures.
 <i>(Patient Initials)</i>	That WCCHC reserves the right to change the above notice and practices, and that the new notice will be available upon request, posted in WCCHC's clinical service sites, and on WCCHC's website.
 <i>(Patient Initials)</i>	That I have been offered a copy of WCCHC's Payment Expectations .
 <i>(Patient Initials)</i>	That WCCHC staff may acknowledge my presence in WCCHC's clinical service sites should someone call to ask for me.
 <i>(Patient Initials)</i>	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 WCCHC is not required to agree to the restrictions requested. For questions, I can contact the WCCHC Compliance Department at 808-697-3585 or via email at compliance@wcchc.com .
 <i>(Patient Initials)</i>	That I may revoke this consent in writing at any time, but that such revocation will not apply to my health information which WCCHC has already used or shared in reliance of this consent.
 <i>(Patient Initials)</i>	That WCCHC is a teaching facility and there will be occasions when interns, residents, students or volunteers may be assisting my health care worker. I understand that I can decline interns, residents, student or volunteers assisting a health care worker by making this known (verbally or in writing) at any time to a WCCHC health care worker involved in my care or management.
 <i>(Patient Initials)</i>	That according to Hawaii law, I may choose to pay for services pertaining to HIV or AIDS treatment if I do not want my health information to be provided to my insurance company or anyone else without my written consent. I agree to notify WCCHC of my wishes regarding payment before these services are provided and if I fail to pay for these services, the information will be sent to my insurance company or anyone else without my written consent. I understand that WCCHC must abide by federal and state laws, regulations or rules regarding communicable diseases, and that even if I pay for a HIV test or AIDS treatment, WCCHC will report positive test results to the Hawaii Department of Health.
 <i>(Patient Initials)</i>	I understand that I have a right to request a paper or electronic copy of my medical records and requesting an amendment to those records by following WCCHC procedures in making such requests.

OPTIONAL COMMUNICATIONS

 <i>(Patient Initials)</i>	By my initials, I request to receive fundraising materials.
 <i>(Patient Initials)</i>	By my initials, I request to receive marketing materials.

AUTHORIZATION FOR COMMUNICATIONS

I understand that my health care provider, their assistants or receptionists, and any WCCHC workforce member may need to contact me by telephone. In the event that I am not available, by my initials below I hereby expressly give my permission to leave the following information on an answering machine and/or my cellular phone, or with any other member of my household or by mail:

<u> </u> (Patient Initials)	Appointment reminders or rescheduling of appointments, including OB/GYN or Behavioral Health (including psychiatric and/or substance use disorder treatment) visits
<u> </u> (Patient Initials)	Scheduling of an immediate follow-up visit due to positive laboratory or diagnostic imaging results (NOTE: results will only be given directly to me or my legally responsible representative)
<u> </u> (Patient Initials)	Billing and insurance inquiries

I understand that the **Health Insurance Portability and Accountability Act of 1996 (HIPAA)** allows my health care provider to communicate about me to my family, friends, legal representatives, or others involved in my care, whom I have designated in writing.
By signing this form, I am granting permission for WCCHC’s providers to communicate with the individuals listed below on any and all health information, medications, test results, recommended therapy or tests, which the provider deems necessary for individuals listed below to know while they are involved with my care. My signature below is voluntary and I can withdraw consent at any time for the following listed individuals to receive my health information.

PRINT NAME:	RELATIONSHIP:	CONTACT #:
PRINT NAME:	RELATIONSHIP:	CONTACT #:
PRINT NAME:	RELATIONSHIP:	CONTACT #:
PRINT NAME:	RELATIONSHIP:	CONTACT #:

I want to designate the person below for WCCHC to discuss **billing** issues on my behalf:

PRINT NAME:	RELATIONSHIP:	CONTACT #:
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This consent will expire in **ONE YEAR** from the date signed below, unless otherwise revoked. If I want this consent to expire sooner than **ONE YEAR**, I will indicate by entering another date here:

Date of Expiration:

Printed Name of Patient or Legally Responsible Party:	Date of Birth:
Printed Name of Legally Responsible Party, if not Patient:	
Signature of Patient or Legally Responsible Party:	Date:
Relationship to Patient, if not signed by Patient:	

FOR STAFF USE ONLY

Consent Processed By:	Title:	Date:
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