Aloha Kona Primary Care

Aloha and Welcome to the Aloha Kona Primary Care Practice,

Our mission is to provide outstanding service and experiences around helping people achieve their health goals. We will strive to make sure that you have a wonderful time at our office as we grow. Your satisfaction is our number one priority, and we wouldn't be able to expand into Family Medicine & Women's GYN Health, if it wasn't for your support.

Included is your new patient packet. Please fill this out completely and return to us *before* your appointment. If you are unable to return this packet ahead of time, please bring them with you 15 minutes prior to your scheduled appointment.

We charge a fee for service, but offer a sliding scale to help those who are eligible. Please ask us for an eligibility form if you would like to be considered.

We look forward to seeing you soon,

The Transformation Health Network Team

PATIENT INFORMATION

To Our Patients: Aloha! We strive every day to give our best in your care. Please know that for our providers to do so, all information must be filled out completely. We want to give you the very best care because … you deserve it and #WE SEE YOU!

Please fill this out in its entirety.

Last Name	First Name		Middle Initial	Social Security Number	
Street Address	City	State	Zip Code	Date of Birth (MM/DD/YYYY)	Age
Primary Phone #	Email Address				
☐ Male ☐ Female	☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow				
Preferred Pharmacy (Name & Address/Phone #):					

PRIMARY INSURANCE

Holder: _____

Insurance Co: _____

Group #: _____

Member id: _____

Phone: _____

SECONDARY INSURANCE (if applicable)

Holder: _____

Insurance Co: _____

Group #: _____

Member id: _____

Phone: _____

EMPLOYER

Name: _____

Address: _____

City, State Zip: _____

Occupation: _____

Phone: _____

EMERGENCY CONTACT

Name: _____

Relationship: _____

Phone 1: _____

Phone 2: _____

May we share personal medical information? ☐ Yes ☐ No

CURRENT MEDICATIONS

_____

_____

_____

ALLERGIES

_____

_____

_____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to the provider or clinic. I authorize my provider to release all information necessary to communicate with personal physicians and other healthcare providers and payers and to secure the payment of benefits. I understand that I am responsible for all costs of medical care, regardless of insurance coverage.

The patient understands and agrees to allow this office to use their Patient Health Information for the purpose of treatment, payment, healthcare operations, and coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

Patient / Guardian Signature _____ *(If guardian, write name please)* _____ Date _____

PATIENT MEDICAL HISTORY

PATIENT NAME: _____ **DOB:** _____ **Date:** _____

PRIMARY CARE PROVIDER _____

What is your preferred Pharmacy? _____
Pharmacy Address or Phone #:_____

Please check all current or previous conditions so that your provider can give the best care available.

Yes	No		Yes	No		Yes	No	
☐	☐	AIDS	☐	☐	Headaches	☐	☐	Scarlet Fever
☐	☐	Anemia	☐	☐	Heart Problems or Disease	☐	☐	Scarring / Keloids
☐	☐	Arthritis, Rheumatism	☐	☐	Hepatitis – type:	☐	☐	Seizures / Convulsions
☐	☐	Asthma	☐	☐	Herpes	☐	☐	Shortness of Breath
☐	☐	Back Problems	☐	☐	High Blood Pressure	☐	☐	Sinus Trouble
☐	☐	Cancer	☐	☐	HIV Positive	☐	☐	Skin Rash
☐	☐	Carotid Artery Disease	☐	☐	Jaundice	☐	☐	Special Diet / Weight Loss
☐	☐	Chemical Dependency	☐	☐	Jaw Pain	☐	☐	Spinal Injury
☐	☐	Chemotherapy	☐	☐	Kidney Disease	☐	☐	Stroke
☐	☐	Circulatory Problems	☐	☐	Liver Disease	☐	☐	Swollen Feet or Ankles
☐	☐	Cortisone Treatments	☐	☐	Low Blood Pressure	☐	☐	Swollen Neck Glands
☐	☐	Cough	☐	☐	Lung Disease	☐	☐	Temporal Arteritis
☐	☐	Diabetes	☐	☐	Migraines	☐	☐	Thyroid Problems
☐	☐	Emphysema	☐	☐	Nervous Problems	☐	☐	Tonsilitis
☐	☐	Epilepsy	☐	☐	Neurological Disease	☐	☐	Tuberculosis
☐	☐	Fainting or Dizziness	☐	☐	Prostate Disorder	☐	☐	Tumors or Growths
☐	☐	Gastrointestinal Disease	☐	☐	Psychiatric Disorder or Care	☐	☐	Ulcers
☐	☐	Glaucoma	☐	☐	Radiation Treatment	☐	☐	Venereal Disease
☐	☐	Head Injury	☐	☐	Respiratory Disease	☐	☐	Other

DENTAL HISTORY

Yes	No		Yes	No		Yes	No	
☐	☐	Bad Breath	☐	☐	Food collection in teeth	☐	☐	Mouth pain
☐	☐	Bleeding Gums	☐	☐	Foreign objects in mouth	☐	☐	Orthodontics
☐	☐	Blisters (mouth or lips)	☐	☐	Grinding teeth	☐	☐	Pain around ear
☐	☐	Burning Sensation	☐	☐	Gums swollen/tender	☐	☐	Periodontal treatment
☐	☐	Chewing on one side	☐	☐	Jaw pain/tiredness	☐	☐	Sensitivity to cold
☐	☐	Clicking or Popping Jaw	☐	☐	Lip or cheek biting	☐	☐	Sensitivity to heat
☐	☐	Dry Mouth	☐	☐	Loose teeth / broken fillings	☐	☐	Sensitivity to sweets
☐	☐	Fingernail biting	☐	☐	Mouth breathing	☐	☐	Other

⇩ **Please continue on the back** ⇩

VISION HISTORY

Yes	No	
☐	☐	Cataracts
☐	☐	Corneal Disease
☐	☐	Crossed Eyes
☐	☐	Diabetic Retinopathy
☐	☐	Macular Degeneration
☐	☐	Retinal Detachment
☐	☐	Retinal Disease
☐	☐	Retinitis Pigmentation

ADDITIONAL QUESTIONS

Yes	No		
☐	☐	Do you smoke? # per day	_____
☐	☐	Do you drink? # per day	_____
☐	☐	Pregnant or nursing?	_____
☐	☐	Hospitalizations?	_____
☐	☐	Surgeries?	_____

_____

_____

_____

Other medical conditions or concerns? _____

LIFE HISTORY

Yes	No		
☐	☐	Do you feel safe at home? In your current relationship?	_____
☐	☐	Do you have suicidal tendencies or thoughts?	_____
☐	☐	Are you/your children safe?	_____
☐	☐	Survivor of sexual assault?	_____
☐	☐	Would you like prayer for your current situations? Please specify:	

_____

_____

_____

Is there anything you would like to discuss with your provider?

Patient / Guardian Signature: _____ **Date:** _____

HIPAA COMPLIANCE PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You also consent to our sharing information with law enforcement should it be necessary.

You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? ▢ YES ▢ NO

May we leave a message on your answering machine at home or on your cell phone? ▢ YES ▢ NO

May we discuss your medical condition with any member of your family? ▢ NO ▢ YES

If YES, please name the members allowed: _____

This consent was signed by: _____ (PRINT NAME PLEASE)

Patient / Guardian Signature: _____ Date: _____

Witness: _____ Date: _____

MEDICAL RECORDS RELEASE FORM

75-5995 Kuakini Hwy. Suite 213 Kailua Kona, HI 96740
Email: office@alohakonaurgentcare.org Phone: (808) 365-2297 Fax: (808) 339-3702

PATIENT INFORMATION

Last Name	First Name		Middle Initial	Social Security Number
Street Address	City	State	Zip Code	Date of Birth (MM/DD/YYYY)
Primary Phone #	Email Address			

RECORDS REQUESTED FROM:

Doctor's Office / Physician Name: _____

Phone #: _____ Fax #: _____

E-mail: _____

Address: _____ City: _____ State: _____ Zip Code: _____

RECORDS RELEASED TO:

Doctor's Office / Physician Name: _____

Phone #: _____ Fax #: _____

E-mail: _____

Address: _____ City: _____ State: _____ Zip Code: _____

I, _____ (print name), hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearing house, consumer reporting agency, employer, or family member to release confidential health information about me, by releasing a copy of my medical record, or a summary or narrative of my protected health information.

All Medical Information From Date: _____ To Date: _____

Patient Name: _____ (PRINT NAME PLEASE)

Patient / Guardian Signature: _____ Date: _____

75-5995 Kuakini Hwy. Suite 213 Kailua Kona, HI 96740
Email: office@alohakonaurgentcare.org
Phone: (808) 365-2297 ext.6 Fax: (808) 339-3702
https://alohakonaurgentcare.org

Transformation Health Network Billing and Collection Financial Policy

Welcome to Transformation Health Network.

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible care and to your treatment being successful. Your clear understanding of our financial policy is important to our professional relationship. Please understand that payment of your bill is considered part of your overall treatment. To keep your cost of healthcare to an absolute minimum, we have adopted the following policies.

Fees and Payments

_____ (Initial) Fees are standardized and are based on the complexity of your visit or procedure. Payment of co-payments and any outstanding balance is required at the time of service. We accept cash, personal checks, money orders, Visa, MasterCard, Discover and American Express. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date that services are rendered. For us to file a claim, you must present a current copy of your insurance card at each visit and communicate any changes in your personal contact information.

_____ (Initial) Most insurance policies specify that some of the cost of the patient's care is the patient's responsibility. This can be accomplished through any combination of co-payments, coinsurance, or deductibles. Copayments are due when you check in for your appointment. Coinsurance and deductibles are determined by your insurance company and reported to us on your explanation of benefits. Once we are notified, we will add the appropriate charge to your account and send you a statement. This charge is payable upon receipt of the statement. Once payments are received, they will be automatically applied to the oldest outstanding balance. If you would like a payment to be applied to a specific charge, please notify our staff at the time of payment.

Insurance Plans

_____ (Initial) Your insurance coverage is a contract between you, your employer, and the insurance company; we are not a party to that contract. We must emphasize that as healthcare providers, our relationship is with you, not with your insurance company. Before your visit, please contact your insurance company to verify the physician that you are scheduled with, participates with your plan and that the services that you intend to receive are covered. In addition, because some insurance plans require either pre-certification and/or a referral from a primary care provider before you can be seen, please ask if these are required and obtain them if necessary.

_____ (Initial) Not all services are a covered benefit in all plans, so it is very important that you understand the provisions of your individual policy. Some insurance companies arbitrarily select certain services they will not cover and so we cannot guarantee payment of all claims by your insurance company. If your insurance company pays only a portion of your claim or rejects your claim, they will notify you through an explanation of benefits. Reduction or rejection of your claim by your insurance company does not relieve you of your financial obligation.

CONTINUED ON NEXT PAGE

Screening Procedures

Insurance plans will only cover services that they determine to be medically reasonable or necessary. Please note that if you are scheduled for screening procedure and any condition or diagnosis is found both the screening diagnosis and the discovered condition are required to be reported. Some insurance plans including Medicare have different coverage for screening versus diagnostic procedures, so it is important that you understand your benefits carefully.

Procedure Charges

_____ (Initial) Patients undergoing in house procedures could receive two separate bills. One bill is the physician's fee and the other will be the facility where your procedure was performed. In addition, if a biopsy is done during a procedure, you may receive an additional bill from the lab facility that reviews and gives a summation of your biopsy. Please contact the lab facility directly to discuss any questions with your lab bill.

Making and Keeping Appointments

_____ (Initial) If you need to cancel your appointment, please call at least 24 hours in advance. This allows us to accommodate other patients who need to be seen. No shows will result in a charge being added to your account and you may also be dismissed from the practice. If you cancel and/or fail to show up for an appointment three (3) times in a calendar year, your care with us will be suspended for 6 months. Please note: your first missed appointment will be forgiven. The second missed appointment will result in an administrative charge of $50, the third will result in an administrative charge of $100.

Non-Payment of Outstanding Accounts

_____ (Initial) Accounts that are not paid in a reasonable amount of time will be handled by our in-house collections staff. If this occurs, you may also be dismissed from the practice. In addition to your outstanding balance, you may also be responsible for any fees or charges that we incur from any agency while attempting to collect your balance.

Administrative Fees

_____ (Initial) **Forms Charge** – If your employer requires Family Medical Leave Act or Disability paperwork to be completed by your provider, the turnaround time is five business days and there is a $35 fee for this service, payable in advance.

_____ (Initial) **Medical Records Charge** – If you would like a copy of your medical records sent to yourself, these copies are billed on a per page basis, payable in advance, in accordance with HIPAA and Hawaii state law. The per page fee schedule is available upon request. If a collaborating physician (primary care or specialist) requests portions of your chart to assist in your care, there is no charge.

_____ (Initial) **Returned Check Charge** – Non-Sufficient Funds (NSF) checks are subject to a $25 fee (in addition to fees from your bank).

Acknowledgement

I, _____ (*print full name*), have read and agree to the billing and collection policy, as described above.

_____ _____

Signature Date