PUKALANI FAMILY PRACTICE, LLC

81 Makawao Ave. Ste. 100, Makawao HI 96768

REGISTRATION FORM

PATIENT INFORMATION

Patient's **LAST** name as it appears on insurance card:	**First** name:	**Middle** inl:	Former name:
Mailing address:	City:	State:	Zip code:
Physical address (if different): (Needed for certain medications)	City:	State:	Zip code:
Home phone #:	Cell phone #:	Work phone #: Can we call this #: YES NO	

MAY WE LEAVE A MESSAGE REGARDING APPOINTMENTS? YES NO **if YES, which number:**
If YES (Message Type) BRIEF OR DETAILED

Birth date:	Age:	Sex:	Marital Status:	Social Security #:
Employer :			Occupation :	
Enthicity: (Circle One) **HISPANIC/LATIN NOT HISPANIC/LATIN REFUSE TO STATE**			Race:	Preferred Language:
Pharmacy :	**Email** (for access to your personal health records):		How did you hear about our office?:	

IN CASE OF EMERGENCY

Name of relative or local friend:	Relationship to patient:	Home phone #:	Cell phone #:
Do you authorize release of your medical information to anyone besides your insurance carrier? □ Yes □ No	If Yes, Whom?		
If patient is a child, who may Authorize treatment for child?	Relationship to child:	Phone:	

INSURANCE INFORMATION
(PLEASE GIVE YOUR INSURANCE CARD TO RECEPTIONIST)

Are you covered by insurance? (circle one) Yes No – self pay

Person responsible for bill ?	**Birth date:**	**Home phone #:**	Address (if different from above)

Is this person a patient here? (circle one) Yes No

Primary insurance:	Subscriber/ID #:	PCP name: Circle one: HMO PPO
Subscriber's name:	Birth date:	Relationship to patient: (circle one) Self / Spouse / Child / Other:
Secondary insurance:	Subscriber/ID #:	PCP name: Circle one: HMO PPO
Subscriber's name:	Birth date:	Relationship to patient: (circle one) Self / Spouse / Child / Other:

The above information is true to my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance and have read and understood the FINANCIAL POLICY AGREEMENT. I also authorize PUKALANI FAMILY PRACTICE, LLC or my insurance company to release any information required to process my claims. I authorize and give consent to PUKALANI FAMILY PRACTICE, LLC and whomever they may designate as their assistants, for medical treatment and for reasonable and necessary services including but not limited to, emergency care, administration of approved drugs, nursing care, pathology, as well as do a medication history check, and other medical services provided as part of my medical treatment.

Patient/ Guardian signature:	Relationship to patient:	Date:

Pukalani Family Practice, LLC

Receipt of Notice of Privacy Practices
Written Acknowledgement Form (HIPAA)

I, _____, have reviewed a
(Print Patients Name)

copy of the notice of Private Practices

_____ _____
(Signature of Patient/Guardian) (Date)

81 Makawao Ave Ste 100
Makawao, HI, 96768
Tel: 808 573 8900 Fax: 808 572 3027

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Makawao, HI 96768

Financial Policy

Dear Patient

Our Practice strives to provide you with the very best healthcare possible. Your insurance contract is between you, your employer (if applicable) and your insurance company. While we try to assist you the best we can with your medical claims, **you the patient** are ultimately responsible for payment of services rendered at our office. It is your responsibility to know what services are covered and what limits, co-pays and deductibles apply.

We are contracted with most insurance companies and, as a courtesy, we will submit your insurance claims to these companies. Should we not receive payment for any reason, including those listed below, you will be sent a statement and will be liable for the charges incurred:

- A basic office co-pay and past due balances are due at the time of your current appointment. Should you receive additional office procedures, and/or consumables you may be sent an invoice for the outstanding amounts.
- Termination or non-enrollment with insurance plan at the time of service.
- Consumables not covered or payment that is less than our costs.
- Injectables that are not covered or payment that is less than our costs.
- Non-Covered Services – Your insurance company may not pay for a particular item or service. This does not mean that you should not receive it. Please check with your insurance company if you have any questions prior to procedures being performed. You will be held liable for costs not covered.
- PCP coverage – If your plan indicates that you have to work through an allocated Primary Care Provider (PCP), it is your responsibility to ensure that our office is listed as your PCP prior to being seen. Non-payment of services we provide due to you seeing the wrong PCP will be passed on to you.
- Medically necessary services – Your insurance company may deem that some procedures are not medically necessary. As your healthcare provider we provide you with the best healthcare we feel is appropriate. Charges not covered will be passed on to you.
- Cancellation policy – we require a minimum of 1 hour notice to cancel or reschedule a routine appointment. Our policy is to charge a patient $25.00 on the third occurrence and each occurrence thereafter during any given calendar year. Repetitive late cancellations or rescheduled appointments may cause dismissal from our practice.
- No shows – our policy is to charge a patient $25.00 on the second occurrence and each occurrence thereafter during any given calendar year. Repetitive no shows may cause dismissal from our practice.
- Annual physicals – due to the hour set aside for care, we require 24 hours notice to cancel the appointment. There will be a $25 charge if we are not given enough notice or it is missed altogether regardless of this being the first time missing an appointment.
- Returned checks – should your check not be honored by your financial institution we will charge a $25.00 fee.

Our office understands that you may need to set up a payment plan. We will work with you to come up with an arrangement that works for us both. We will not charge interest on accounts where the payment plans are being honored.
Delinquent accounts will be subject to interest. Accounts older than 120 days are subject to being sent to collections and possible dismissal from our practice.

Should you have any questions regarding our Financial Policy, please ask to speak to a member of our accounts department.

DATE…….

PRINT NAME …….* PATIENT □ / GARANTOR □

SIGNATURE…….

* If the patient is under 18 years and a minor this form needs to be signed by the Guarantor of the account.