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

Pukalani Family Practice, LLC
81 Makawao Avenue Ste. 100
Makawao, HI 96768

HIPAA EMAIL CONSENT

Important Information:

- HIPAA stands for the Health Insurance Portability and Accountability Act.
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information.
- Information stored on our computers is protected.
- Most popular email services (Ex. Hotmail®, Gmail®, Yahoo®) do not utilize encrypted email.
- When we send you an email, or you send us an email, the information that is sent is not encrypted. This means a third party may be able to access the information and read it since it is transmitted over the internet. In addition, once the email is received by you, someone may be able to access your account and read it.
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA.
- The guidelines state that if a patient has been made aware of the risks of an unencrypted email, and if that same patient provides consent to receive health information via email, then a health entity may send that patient personal health information via unencrypted email.

By consenting to the use of email with Pukalani Family Practice, LLC, you agree that:

- Pukalani Family Practice, LLC may forward/receive emails as appropriate for placement, diagnosis, treatment, reimbursement, and other related reasons. As such, Pukalani Family Practice, LLC's staff may have access to emails you send. Such access will only be to people who have a right to access your e-mail to provide services to you. Pukalani Family Practice, LLC will not forward emails to independent third parties without your prior written consent, unless as authorized by patient or required by law.
- You will not use email communication for medical treatment of any kind and that you will always contact our office for medical treatment and related questions.
- Pukalani Family Practice, will not communicate by email regarding highly sensitive subjects such as 1)HIV/AIDS or STDs; 2) questions or problems of a sexual nature; 3) alcohol or drug dependence or treatment; or 4) questions about my mental health.
- Emails are not checked outside of normal business hours – this includes overnight, on weekends or holidays.
- We will try to respond to email messages within 24 hours. However, there is no way to guarantee that this will occur, for a variety of legitimate reasons. (Examples: misaddressed email, server down, electric power failure, etc.) If you do not get a response from this office by email or telephone within 24 hours, it is your responsibility to contact Pukalani Family Practice, LLC by telephone, mail, fax, or in person.
- If at any time you change your email address or wish to discontinue email communications altogether, you must notify Pukalani Family Practice, LLC immediately in writing.

ACKNOWLEDGMENT AND AGREEMENT

Pukalani Family Practice, LLC will use reasonable means to protect the privacy of the patient's health information. However, because of the risks outlined above, Pukalani Family Practice, LLC cannot guarantee that e-mail will be confidential. Additionally, Pukalani Family Practice, LLC will not be liable in the event that you or anyone else inappropriately uses or accesses your e-mail. Pukalani Family Practice, LLC will not be liable for improper disclosure of your health information that is not caused by Pukalani Family Practice, LLC's intentional misconduct.

By signing this form, I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communications of email between Pukalani Family Practice, LLC and me, and consent to the conditions outlined herein, as well as any other instructions that Pukalani Family Practice, LLC may impose to communicate with me by email. Any questions I may have had were answered. I understand that this consent is valid until I revoke the consent as outlined above, except to the extent that a person who is to make a communication has already acted in reliance upon this authorization.

Please select an option below:

OPTION 1 – **ALLOW** UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission to (Pukalani Family Practice. LLC) to send me personal health information via unencrypted email regarding patient _____.
Patient name

_____ _____ _____ _____
Signature **Date** **Printed name** **Please clearly print ONE email address**
(Parent or guardian if patient is a minor)

OPTION 2 – **DO NOT ALLOW** UNENCRYPTED EMAIL

I do not wish to receive personal health information via email for patient _____.
Patient name

_____ _____ _____
Signature **Date** **Printed name**
(Parent or guardian if patient is a minor)

OPTION 3– **REVOKE** UNENCRYPTED EMAIL

I wish to revoke unencrypted email communication regarding personal health information via email for patient _____.
Patient name

_____ _____ _____ _____
Signature **Date** **Printed name** **Please clearly print email address**
(Parent or guardian if patient is a minor)

Also Pukalani Family Practice, LLC has the right to revoke unencrypted email communication regarding personal health information via email.

☐ REVOKE Date: _____ Reason: _____

We will only send/receive Personal Health Information from the email addresses written on this form.

Pukalani Family Practice, LLC
81 Makawao Avenue Ste. 100
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.

***Patient Name*:**_____

HEALTH HISTORY QUESTIONAIRE:

Please list last Primary Care Physician or Facility: _____

Please list when and where you last completed the following:

Name:	**Date:**	**MD/PA/APRN or Facility**
Physical Examination	_____	_____
Dental Exam	_____	_____
Eye Exam	_____	_____
Diabetic eye exam	_____	_____
Tetanus vaccine	_____	_____
Flu Vaccine	_____	_____
Pneumococcal Vaccine	_____	_____
Colonoscopy	_____	_____
Pap Smear	_____	_____
Mammogram	_____	_____
DEXA scan	_____	_____

PAST MEDICAL HISTORY

Please **check** ☑ **any** conditions you have been diagnosed with by a **Medical Doctor:**

AAA(Abdominal Aortic Aneurism)	
Abnormal Fasting Blood Sugar Test	
Acne	
ADHD	
Atrial Fibrillation	
Aortic Insufficiency	
Alcohol Abuse	
Allergic Rhinitis	
Alzheimer's DS	
Anemia	
Anxiety Disorder	
Asthma	
Bipolar Disorder	
Benign Prostatic Hypertrophy	
Coronary Artery Disease	
Cardiac Arrhythmias	
Cancer: **Type**:_____ **Type**:_____	
Cardiomyopathy	
Carotid Stenosis	
Carpal Tunnel	
Cataract	
Congestive Heart Failure	
Cholelithiasis (Gallstones)	
Chronic Pain Syndrome	
Cirrhosis of Liver	
Chronic Kidney Disease	
Colon Polyps	
COPD\Emphysema	
Crohn's Disease	
Cushing Disease	
CVA/Stroke	
Disc Disease Neck	

Disc Disease Lower Back	
Depression	
Diverticulosis	
Degenerative Joint Disease Body Part:	
Diabetes – Type 1	
Diabetes – Type 2	
Down's Syndrome	
Drug Abuse	
Deep Venous Thrombosis	
Abnormal Cholesterol Levels	
Eczema	
Endometriosis	
Erectile dysfunction	
Fibrocystic Breast Disease	
Gastro esophageal Reflux Ds	
Glaucoma	
Gout	
Guillain-Barre' Syndrome	
Hepatitis C	
Heart Attack/MI	
Heart Murmur	
HIV	
Hodgkin's Disease	
Hard of Hearing	
High Blood Pressure	
Polio	
Hyperactive Bladder	
Hyperparathyroidism	
Hyperthyroidism	
Hypothyroidism	
Irritable Bowel Syndrome	
Insomnia	
Internal Derangement of Knee	
Kidney Stones	
Lower Back Pain	
Lupus	

Migraine Headaches	
Multiple Sclerosis	
Neck Pain	
Osteoarthritis	
Obesity	
Osteoporosis	
Ovarian Cystic Disease	
Peripheral Artery Disease	
Pancreatitis, Chronic	
Panic Attacks	
Parkinson Disease	
Peripheral Neuropathy	
Pre Menstrual Syndrome	
Positive PPD/TB Test	
Psoriasis	
Post Traumatic Stress Disorder	
Peptic Ulcer Disease	
Pulmonary Hypertension	
Peripheral Vascular Disease	
Rheumatoid Arthritis	
Rosacea	
Rotator Cuff Syndrome	
Schizophrenia	
Scoliosis	
Seizure Disorder	
Sinusitis, Chronic	
Sleep Apnea	
Spinal Stenosis	
Subarachnoid Hemorrhage	
Subdural Hematoma	
TIA (Stroke)	

PAST SURGICAL HISTORY

Please **check** ☑ **any** surgeries completed and list the year when done.

		Year
A/C Separation Repair		
Aneurysm Coil		
Appendix Removed		
Breast Augmentation		
Breast Reduction		
Bilateral Tubal Ligation		
C Section		
Coronary Arterial Bypass Graft		
Cardiac Valve Surgery		
Carotid Endarterectomy		
Carpal Tunnel Surgery		
Gall Bladder Removed		
Ectopic Pregnancy		
Gastric Bypass		
Hemorrhoid Removal		
Hernia Repair *Circle One: Umbilical / Abdominal / Inguinal / Hiatal		
Hip Replacement		
Hysterectomy		
Knee, Open Procedure *circle one (right or left)		
Knee Arthroscopy *circle one (right or left)		
Knee Replacement *circle one (right or left)		

		Year
Kidney Stone Crushing		
Abdominal Surgery		
Laparoscopy		
Breast Removed		
Melanoma Removed		
Kidney Removed		
Surgery for Bone Fracture Using pins or plates		
Pacemaker/Defibrillator		
Prostate Removed		
Cardiac Angioplasty/Stent		
Rotator Cuff Repair *circle one (right or left)		
Spinal Surgery: *Circle One: L-Spine /T-Spine /C-Spine		
Spleen Removed		
Tonsils Removed		
Total Abdominal Hysterectomy		
Thoracotomy (Chest Incision)		
Thyroid Removed		
Transurethral Resection of Prostate		
Vasectomy		
Vein Stripping		

FAMILY HISTORY

☐ **I'M ADOPTED** (SKIP TO CHILDREN QUESTION)

MOTHER:	**FATHER:**
Alive Year Born ____	Alive Year Born ____
If Deceased Age when passed____	*If Deceased* Age when passed____
Cause of death_____	Cause of death_____
History: **(Circle)** diabetes / heart disease / dementia	History: **(Circle)** diabetes / heart disease / dementia
high blood pressure / stroke / COPD / cancer-type:_____	high blood pressure / stroke / COPD / cancer-type:_____

SIBLINGS ☐Yes ☐ No ☐ Unknown

Brother(s) How many____ (**Circle)** diabetes / heart disease / high blood pressure / stroke / COPD / dementia / cancer

Sister (s) How many____ (**Circle)** diabetes / heart disease / high blood pressure / stroke / COPD / dementia / cancer

If deceased, *reason and age at time of death:*

#1: From _____ Age _____ ☐ Sister ☐ Brother

#2: From _____ Age _____ ☐ Sister ☐ Brother

#3: From _____ Age _____ ☐ Sister ☐ Brother

#4: From _____ Age _____ ☐ Sister ☐ Brother

CHILDREN ☐Yes ☐ No

How many male ____ Health Issues:_____

How many female ____ Health Issues:_____

SOCIAL HISTORY

Please **check** ☑ applicable box and answer:

Cigarette Smoker: ☐ **Never**(skip to next box)

☐ **Currently smoking** Cigarettes per day?_____ Total years smoking?_____

☐ **Past** Cigarettes per day?_____ Total years smoked?_____ Year quit? _____

Non-prescription/recreation drug use ☐ **Never** (skip to next box)

☐ **Currently use** Please list types using:_____

☐ **Used in the past** Please list types used:_____

Are you currently: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

What year were you married/divorced/widowed? _____

Current Employment Status:

☐Unemployed ☐ Disabled ☐Student ☐Retired ☐Self-employed ☐ Minor

Employed as:_____

Is there a firearm in your home? ☐ Yes ☐ No

Do you regularly drink alcohol? ☐ Yes ☐ No

-How many drinks _____ per (**circle**) day / week / month

Pukalani Family Practice

Rob Mastroianni MD

Tel: 808 573 8900 Fax: 808 573 7505
Pukalani Square
81 Makawao Ave Ste 100, Makawao, HI 96768

Re: Patient Name: _____

Date of Birth: _____

I hereby authorize:

Doctor	Tel #	Fax #
_____	/	/ _____
_____	/	/ _____
_____	/	/ _____
_____	/	/ _____
_____	/	/ _____

to release the following information to: **Pukalani Family Practice "Continued Care"**

****In order to conserve time and paper please send only what is requested below.****

*Information to be disclosed:		*Purposes of Use and/or Disclosure:
__ Current Medications	__ All Pap/LEEP/Colposcopy	
__ Current Labs/Pathology	__ Mammo	__Legal purposes
__ All Radiology Records	__ Colonoscopy	
__ Immunizations	__ Diabetic Eye Exam	__At request of patient
__ Last 3 Progress Notes	__ Annual Physical	
__ All Specialist Consults		__Continuity of Care
Other: Please specify		__Other:
_____		
_____		

This authorization includes, but is not limited to, any and all information relating in any way to the diagnosis, treatment, referral, or rehabilitation rendered to the individual pertaining to (1) alcohol, drug, or other substance use or abuse; (2) mental health or mental illness; (3) sexually transmitted diseases including human immunodeficiency virus ("HIV") infection, acquired immune deficiency syndrome ("AIDS"), or AIDS related complex ("ARC"). I understand that specific consent may be required to release such information, and I herby give such specific consent. If applicable, I hereby waive all requirements of any and all state and federal laws and regulations restricting the release, use and dissemination of the information.

This authorization is voluntary. I understand that the above named health care provider(s) or Health plan(s) will not condition my treatment, payment, enrollment or eligibility for benefits on the signing of this authorization except as allowed by law.

This release is valid for one Year from the date signed. I understand that I may revoke this authorization at any time by notifying the above named provider(s), in writing of my revocation. I understand that the revocation will not apply to any information that is already released or used in reliance on this authorization and there may be other legal restrictions on my ability to revoke this authorization. I understand that the revocation will not apply if the authorization was obtained as a condition of obtaining insurance coverage, when the law provides my insurer with the right to contest a claim under my policy itself.

A photocopy of this Authorization is valid as an original.

_____

PRINT NAME

_____

SIGNATURE