



# ALOHA KONA HEALTH CARE SERVICES

A Division of Transformation Health Network

75-5995 Kuakini Hwy, Suite 513 Kailua Kona, HI 96740

Email: [office@thnhawaii.org](mailto:office@thnhawaii.org) // Phone: (808) 365-2297

Is your visit today due to a **work related injury** or **Auto accident**?

If YES- **STOP HERE** and notify the receptionist before registering

## Registration Information

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Patient Name: \_\_\_\_\_, \_\_\_\_\_ Sex at birth: Male / Female  
(Last) (First) (Middle Initial)

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_\_ Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
(mo/da/yr)

Gender: Male / Female / Other: \_\_\_\_\_ Race: \_\_\_\_\_ Preferred Language: \_\_\_\_\_

Ethnicity (circle one): Hispanic / Non Hispanic / Decline to answer Interpreter needed? YES / NO

### Mailing Address:

[non residents: a local physical address is **required** for registration, **no exceptions**. Temporary lodging addresses are acceptable]

(Street) \_\_\_\_\_

(City) \_\_\_\_\_ (State) \_\_\_\_\_ (ZIP code) \_\_\_\_\_ (Country) \_\_\_\_\_

Contact Phone: \_\_\_\_\_ Alternate contact Phone: \_\_\_\_\_  
*(MUST be U.S. phone number)*

\* I consent to receive text messages on my mobile phone (please circle one) Yes / No

Email address: \_\_\_\_\_

**STAY CONNECTED!** For on demand access to your medical record, including visit notes and lab results scan the QR code here to download and enroll in the HEALOW APP



## Insurance Information

Policy Holder Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Relationship to Patient: \_\_\_\_\_ Policy Holders Employer: \_\_\_\_\_

Primary Insurance Carrier: \_\_\_\_\_ Subscriber ID: \_\_\_\_\_

Group ID: \_\_\_\_\_ Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Policy Holder Name: \_\_\_\_\_

DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SSN \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Relationship to Patient: \_\_\_\_\_

Patient: \_\_\_\_\_ Policy Holders Employer: \_\_\_\_\_ Secondary Insurance Carrier: \_\_\_\_\_

Subscriber ID: \_\_\_\_\_ Group ID: \_\_\_\_\_

ID: \_\_\_\_\_ Effective Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

## Emergency Contact

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Phone number: \_\_\_\_\_

Parent/Guarantor Information (fill out if patient is a minor or if billing address is different than mailing address)

What is the patient's relationship to the guarantor? \_\_\_\_\_

Guarantor Name: (Last) \_\_\_\_\_ (First) \_\_\_\_\_ (Middle Initial) \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security # \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Phone Number: \_\_\_\_\_



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## AUTHORIZATION AND RELEASE

By signing this consent form I acknowledge that I have read, understand, voluntarily consent to and authorize the following:  
Authorization of Treatment: The administration and cost of all medical and surgical procedures, and medication for myself and for my dependents.

Initial I acknowledge that a copy of the Notice of Privacy Practices of Aloha Kona Urgent Care (AKUC) is available to me upon request. I understand that a copy of this consent form may be used with the same effectiveness as the original. I have read the Notice of Privacy Practices of AKUC provided to me before signing this form.

## RECORDS RELEASE

Initial I authorize AKUC to release verbally, electronically, and/or in writing confidential medical information for purposes of treatment, payment of charges, quality assurance and utilization review, transfer and follow-up procedures to my insurance carrier, employer (if treatment is related to employment), immediate family member (s), and/or other healthcare providers. I authorize AKUC as an after-hour urgent care provider, per standard of urgent care and AKUC policies, to provide a copy of my treatment summary to the patient's identified primary health care provider for continuum of care. I understand that should I choose to release my medical record to a specific entity, primary care provider, specialist, and/or person(s), such as extended family members, I must specifically state so BELOW in writing to be kept in my medical record.

Name: \_\_\_\_\_

Title/Relation: \_\_\_\_\_

## HIPAA ACKNOWLEDGEMENT OF RECEIPT

**I acknowledge that I have received a copy of the Notice of Privacy Practices from Aloha Kona Health Services.**

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

If signed by personal representative:

Representative Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Initial I also understand that should I want exceptions regarding the release of my records I must also state so in writing.

## SCHEDULING AND APPOINTMENTS

Initial I acknowledge that upon securing an appointment, I will be asked to pay the applicable copay or cost of the visit. With exceptions for extraordinary circumstances to be evaluated by AKUC staff, that payment will not be refunded if I miss the appointment or am late, resulting in a no show.

## GUARANTEE OF PAYMENT

Initial  **SELF PAY** – I elect to pay for all services rendered in full today. I understand that my insurance will NOT be billed by Aloha Kona Urgent Care (AKUC).

Initial  **INSURANCE** – Assignment of Benefits: I authorize payment directly to AKUC for all benefits otherwise payable to me. I also acknowledge that AKUC will submit my bill to my insurance carrier as a courtesy; however, I am ultimately responsible for all charges incurred. I agree that I will pay my estimated balance based on the best available information of my current policy and AKUC's current contract with my insurance carrier. I understand this is only an estimate and after my visit is processed with my insurance company, I will be billed for any outstanding balance and/or refunded for any credit due to or by me. While AKUC makes every effort to verify my correct insurance information prior to leaving, I understand AKUC cannot guarantee the accuracy of my bill until it has been fully processed by my insurance carrier and that I am ultimately responsible for all charges incurred.

Patient/Responsible Party: Print \_\_\_\_\_ Sign \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_



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## GAD-7 Anxiety

Over the <u>last two weeks</u> , how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals         +      +      +      =  
*Total score*        

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all                  Somewhat difficult                  Very difficult                  Extremely difficult

          

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at [ris8@columbia.edu](mailto:ris8@columbia.edu). PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

## Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day." GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety



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## PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the **last 2 weeks**, how often have you been bothered by any of the following problems?

		Not at all	Several Days	More than ½ days	Nearly every day
		<i>(Use "✓" to indicate your answer)</i>			
1	Little Interest or pleasure in doing things				
2	Feeling down, depressed, or hopeless				
3	Trouble falling or staying asleep, or sleeping too much				
4	Feeling tired or having little energy				
5	Poor appetite or overeating				
6	Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
7	Trouble concentrating on things, such as reading the newspaper or watching television				
8	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				
9	Thoughts that you would be better off dead or hurting yourself in some way				
FOR OFFICE CODING		0	1	2	3

\_\_\_\_\_ + \_\_\_\_\_ = \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_ + \_\_\_\_\_  
 Total Score: \_\_\_\_\_

If you checked off **any** problems, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people?

\_\_\_\_\_ Not difficult at all     
 \_\_\_\_\_ Somewhat difficult     
 \_\_\_\_\_ Very difficult     
 \_\_\_\_\_ Extremely difficult