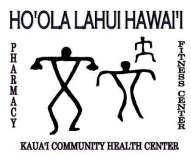
HLH
ON-LINE
FORM



Ho'ola Lahui Hawai'i
Kaua'i Community Health Center
Medical/Dental & Behavioral Health
Client Registration Form

Fill out the information on this form on your computer & then print out and bring it with you to your appointment.

Sliding Fee Discount

If you are uninsured, you may apply for a discount according to your family size and income amounts. If you qualify, you would pay a percentage of any billable charges. If you are interested in this discount, please inform us.

CLIENT / PATIENT INFORMATION:

Last Name: | First Name: | MI

Other (Last Name): | First Name: | MI

Mailing Address: | City: | Zip Code:

Residence Address: | City: | Zip Code:

Home Phone No: | Work Phone No. | Cell Phone No.

☐ Check If Ok to leave message at your Home Phone ☐ Check Box If Ok to leave message at Work Phone ☐ Check If Ok to leave message on Cell Phone

SSN | Date of Birth: | GENDER: ☐ Male ☐ Female

1. RACE:

SELECT ONE ONLY

If Other - List Here:

2. ETHNICITY:

SELECT ONE ONLY

3. Primary Language:

SELECT ONE ONLY

If Other, List Here:

4. Marital Status:

SELECT ONE ONLY

5. Veteran Status

☐ Yes
☐ No
☐ Has Family Members That Are Veterans

EMERGENCY CONTACT INFORMATION:

List Person we may contact in case of emergency (If possible, someone from outside the home.

Name: | Relationship: | Phone No.:

RESPONSIBLE PARTY INFORMATION

- **(If Self, Skip this section and continue to Employer)

Relationship To Client/Patient: ◯ SELF ◯ SPOUSE ◯ PARENT ◯ GUARDIAN

Last Name: | First Name: | MI

Mailing Address: | City: | Zip Code:

Residence Address: | City: | Zip Code:

Home Phone No: | Work Phone No. | Cell Phone No.

☐ Check If Ok to leave message at your Home Phone ☐ Check Box If Ok to leave message at Work Phone ☐ Check If Ok to leave message on Cell Phone

SSN | Date of Birth: | GENDER: ☐ Male ☐ Female

Employer: | Phone No.: | Address:

Family Size: | Family Monthly Income: | City | Zip Code:

HOMELESS: ◯ Not Homeless ◯ Homeless Shelter ◯ On The Street ◯ Doubling Up ◯ Other

If Homeless - List Dates From MM/To YY)

Who may we talk to about your health?	Name:	Relationship:	Phone No.:

PRIMARY Insurance Information: (A copy of all insurance cards are required) ☐ None ☐ Medical ☐ Dental ☐ Both

Primary Insurance: Membership ID # Insured Name:

Address: Date of Birth: Gender

City: Zip Code: SSN ☐ Male ☐ Female

SECONDARY Insurance Information: (A copy of all insurance cards are required) ☐ None ☐ Medical ☐ Dental ☐ Both

Secondary Insurance: Membership ID # Insured Name:

Address: Date of Birth: Gender

City: Zip Code: SSN ☐ Male ☐ Female

Ho'ola Lahui Hawai'i - Authorization and Release Form

I authorize this office to release to the named insurance company any information necessary to secure insurance payment. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand I am responsible for all charges regardless of insurance coverage. Initial Here:

I authorize and consent to any diagnostic and/or medical/dental treatment under the instruction of the attending physician and/or dentist for which my dependent or I have sought care. Initial Here:

I give Ho'ola Lahui Hawai'i (Kaua'i Community Health Center) permission to verify the financial and insurance information provided by me to determine eligibility for Ho'ola Lahui Hawai'i (Kaua'i Community Health Center) services. I understand it is my responsibility to keep Ho'ola Lahui Hawai'i (Kaua'i Community Health Center) informed of any changes in my families income and insurance status. Initial Here:

The information provided is accurate and complete to the best of my knowledge and is only to be used for my treatment, billing, processing of insurance claims, and/or for qualification for services to which I may be eligible. Initial Here:

Non-disclosure to Health Insurance:
I do not want my insurance company billed or notified of today's services. I understand that by doing this I am obligated to pay prior to services being rendered to myself or dependent. Initial Here:

Client Policy and Procedures: **(Please initial)**

I have received a copy of the "HIPAA Notice of Privacy Practices".	☐
I have received a copy of the "Client's Rights and Responsibilities and Grievance Procedure".	☐
I understand that there is a notification period of 24 hours prior to my appointment or my account will be charged $40.00 for any appointment(s) not kept.	☐
I understand that there is a $20.00 service charge for any/all returned checks.	☐

Signature **(Patient/Responsible Party/Legal Guardian)**		Date:	
If Other signing, Please Print your Name here:		Witness:	
Reviewed By:		Date	