Hawaii Family Physicians

75-5870 Walua Rd. #200 Kailua-Kona, HI 96740 P:808-323-3107 F:808-323-0012

David Arthurs, DO Beth Catanzaro, MD Nathan King, MD Marie Thomas, PAC Hannah Montanye, PAC Paul Kyle, PAC Excel Barayuga, PAC

Thank you for your interest in establishing care with our family practice.

Below is a list of conditions that our providers DO NOT manage.

There are certain conditions that are beyond the scope of the providers in our practice. Therefore, do not continue this application if you answer "YES" to any of the following:

1. *Taking any **Controlled** medications (i.e. Oxycodone, Hydrocodone, Alprazolam, Adderall)*
2. *Taking benzodiazepines for any purpose. Examples include but are not limited to: alprazolam (Xanax), diazepam (Valium), lorazepam (Ativan), and Clonazepam (Klonopin).*
3. *Taking any mind-altering substances, marijuana, consume more than 3 alcoholic beverages per day.*
4. *Need treatment for work injuries, or motor vehicle injuries. Those insurances aren't accepted at our practice.*
5. *Need treatment or pre exposure prophylaxis (PrEP) for HIV/AIDS*
6. *Have any **Ohana insurance plan** or **Kaiser Insurance**. (Even if **Kaiser** is your secondary insurance, you may be required to pay the full self-pay rate).*
7. *If you have signed an attestation form (assigning a specific provider as your PCP) with any other provider and/or clinic, **you will** be required to pay the full self-pay rate.*

If after reading the above you realize you're unable to establish care with us, your insurance plan will be able to assist you in choosing a participating Provider.

Additionally:

We ask that **ALL** our patients participate in **Preventable Care and Health Screenings.**
When applicable this includes: Colon Cancer Screenings, Mammograms, Cervical Cancer Screenings, Bone density screenings for osteoporosis, appropriate laboratory studies, wellness checks, and age-appropriate vaccinations.

If you agree to follow the recommended screenings above, please continue to the new patient packet. Remember to fill out all forms completely with signatures and return to us with copies of photo identification and insurance cards, front and back.

Patient/Guardian Printed Name: _____ Date: _____

Patient/Guardian Signature: _____

REVISED APRIL 2024

PATIENT INFORMATION	**HAWAII FAMILY PHYSICIANS**		**PLEASE PRINT CLEARLY**
Legal Name: Last:	First:	Middle:	(I prefer) Nickname:
Maiden Name:	Mailing address: PO BOX	City:	State: Zip:
Required: Permanent Physical Address:		City:	State: Zip:
Social Security # - -	Home # ( )	Cell phone # ( )	Birthdate: Sex: ☐ M ☐ F
Email:	Employer:	Work # ( )	Retired? ☐ Yes ☐ No
My spouse or S.O.'s name:	Spouse's Cell #:	Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐	
I prefer reminders by which of the following methods:	Text ☐ Email ☐ Phone ☐	I understand the link to my patient portal electronic health information will be sent by email	
Names of Family members seen at this office are:			
Preferred Pharmacy:	2nd Preferred Local Pharmacy, if mail order 1st choice:		
RACE: (circle) American Indian, Asian, Black, Pacific Islander, Hispanic, White	Ethnic Group:	Preferred Language:	

Emergency Contact Information ***Include on privacy form if able to share information

Name:	Relationship:	Phone:

Responsible Party Information

Name:	DOB:	Relationship:	Phone:

If YWAM staff /student: Please list immediate family member's name & mainland address for forwarding information. Country?

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD(S) & ID TO THE RECEPTIONIST)

Are you (the patient) covered by insurance? (Check one) YES, I have insurance ☐ I DO NOT HAVE INSURANCE – I will be self-pay ☐

Primary Insurance:		Subscriber's ID or Member Number:		
PCP listed on insurance card:		Effective date:	Do you have Quest? ☐ Yes ☐ No	
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other				
Subscriber's name:	Subscriber's S.S. number:	Subscriber's Birth date:	Group number:	Co-payment:
				$
Subscriber's Occupation:			I am working: ☐ Yes ☐ No	

Secondary Insurance:	Subscriber's ID or Member Number:	
Patient's relationship to subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other	Group#	Co-payment:
Subscriber's name:	Subscriber's S.S. number -- -	

My preferred provider is: or ☐ Does not matter

☐ **Dr. Arthurs, DO** ☐ **Dr. Beth, MD** ☐ **Dr. King, MD** ☐ **Marie, PAC** ☐ **Hannah, PAC** ☐ **Paul, PAC** ☐ **Excel, PAC**

ACKNOWLEDGMENT

I certify that the above information is true to the best of my knowledge. I understand that ***I am authorizing the following:***

1. The administration of medical treatment by the Provider I selected above or any staff at Hawaii Family Physicians.
2. The release of any medical information by Hawaii Family Physicians and my insurance companies required to process claims regarding the above patient and that this may include information relative to substance abuse, HIV status, STDs (sexually transmitted diseases), &/or mental conditions. The release of any necessary medical information to specialists that my provider refers me to.
3. Payment of all basic major medical insurance or Medicaid benefits will be made directly to Hosanna LLC, **Hawaii Family Physicians**, for all medical services rendered to above patient. ***At the time of service,*** I will pay my co-pay and deductible OR if I have no insurance, or an insurance we are not contracted with (Kaiser, Ohana/ WellCare)– ***I will pay in full.*** I agree that I'm financially responsible for any balance and if I choose/request/allow a procedure or injection/vaccines not covered by my insurance plan, I will be responsible for payment in full.
4. I have received the HIPAA Privacy notice. I agree to give HFP one (24 hour+) business day notice for any cancellation or any changes to all appointments or pay the agreed fee of $75 fee for office visits or $100 for scheduled procedures. See no-show policy in patient's rights and responsibilities for further information related to max days allowed for no-shows/late cancellations.

Patient/Parent/Guardian's signature:	***Printed Name:***	***Date***

Medical History for Adolescents and Adults **Name:**_____ **DOB:**_____

Previous Primary Care Provider:

❒ **No Known Drug Allergies** or **List all food or drug allergies:**

Past Medical History

Yes ❒ **No** ❒ Skin Cancer
Yes ❒ **No** ❒ Other Cancers: _____
Yes ❒ **No** ❒ Chronic Lung Disease/Asthma
Yes ❒ **No** ❒ Diabetes
Yes ❒ **No** ❒ Heart Disease
Yes ❒ **No** ❒ High Blood Pressure
Yes ❒ **No** ❒ High Cholesterol
Yes ❒ **No** ❒ Mental Illness
Yes ❒ **No** ❒ Behavioral Health
Yes ❒ **No** ❒ Osteoporosis
Yes ❒ **No** ❒ Stroke
Yes ❒ **No** ❒ Thyroid Disease
Yes ❒ **No** ❒ Work related injuries
List other: _____
_____
_____

❒ **No Significant Medical History to report**

Past Surgical History	**Year Performed**
_____	_____
_____	_____
_____	_____
_____	_____

Hospitalizations

Yes ❒ **No** ❒
Reasons: _____
_____
_____

Family Medical History: List any Medical Problems (i.e., Cancer, Heart, Stroke, etc.)

Father _____
Mother _____
Other Family Member (specify) _____
Brother _____
Sister _____
_____

My Social History Education (Highest year completed in school):_____
Occupation:_____Retired? ❒ Yes ❒ No My ethnic background is:_____
My sexual orientation is: ❒ Gay ❒ Lesbian ❒ Bisexual ❒ Heterosexual ❒ Transgender
My marital status is: ❒ Single ❒ Single & living with significant other ❒ Married ❒ Divorced ❒ Widowed
Who else lives in my home?_____. I have_____(#) children. Their ages are:_____
My exercise/activity level is:_____minutes per day?_____. Stress level? ❒ High ❒ Medium ❒ Low
Do you *smoke* or *chew tobacco*? ❒ Yes ❒ No If so, what?_____per day
At what age did you start smoking?_____If quit, when?_____
Do you use *illegal drugs including marijuana*? ❒ Yes ❒ No If so, what?_____
How much? _____How often?_____per day
Do you drink alcohol? ❒ Yes ❒ No If so, how much and how often?_____per day_____per week
At what age did you start drinking?_____If quit, when?_____
Hobbies & interests:_____
Do you have a ***Living Will*** or an ***Advanced Health Care Directive***? ❒ Yes ❒ No *If so, please provide HFP a copy.*

List all current medications to include mind altering substances, laxatives, birth control, vitamins, diet pills, over the counter meds, narcotics, etc.
***Are you up to date on all adult vaccines*?** ❒ Yes ❒ No

Most Recent Preventive Screenings
****PLEASE PROVIDE RECORD****
Include Year Completed

Medication	**Dosage**	**How often you take it**	**Screenings**	Year completed
			Colonoscopy	YEAR
			Mammogram	YEAR
			Pap Smear	YEAR
			Diabetic Eye Exam	YEAR
			Other:	YEAR

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

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Name:	DOB:

Please answer each question by checking the box and filling in the blank to explain. Check mark anything you wish to discuss with your Provider or medical assistant.

GENERAL

❒ Have you gained more than 10 pounds in the last 6 months?____
❒ Have you lost more than 10 pounds in the last 6 months?_____
❒ Have you recently lost your interest in eating?_____
❒ Are you more thirsty than usual lately? _____
❒ Is there any swelling in your armpits or groin area?
❒ Do you have fever or chills?_____
❒ Do you feel exhausted or fatigued most of the time?_____
❒ Do you feel that you eat a healthy diet?_____
❒ Do you get aerobic exercise? How often?_____
❒ Do you have difficulty with sleep?_____
❒ Do you have any excessive bleeding or bruising?_____
❒ Do you take or have you used any illegal drugs?_____

CARDIOVASCULAR

❒ Are you bothered by pounding, racing, or skipping heartbeat?___
❒ Do you get pains or tightness in your chest?_____
❒ Do you have trouble with feeling lightheaded or passing out?___
❒ Do you get severely short of breath with exertion or exercise?___
❒ Do you wake up at night short of breath?_____
❒ Do you have trouble with swollen ankles or feet?_____
❒ Do you get cramps in your legs while walking? _____
❒ Have you ever been told you have a heart murmur?_____
❒ How many pillows do you sleep on?_____

URINARY

❒ Do you leak urine?_____
❒ Do you have pain or burning when you urinate?_____
❒ Is you urine bloody or black?_____
❒ Do you have a constant feeling that you need to urinate?_____
❒ How many times do you have to get up to urinate at night?_____

MUSCULOSKELETAL & SKIN

❒ Are you troubled with painful or stiff joints?_____
❒ Do you have any skin problems?_____

FOR MEN ONLY

❒ Have you ever had any burning or discharge from your penis?___
❒ Are there any swelling or lumps on your testicles?_____
❒ Have you had difficulties getting or keeping an erection?_____

NEUROLOGICAL/PSYCHOLOGICAL

❒ Do you usually feel sad or lonely?_____
❒ Do you have time periods of feeling super -energized, needing little sleep and making poor choices?_____
❒ Have you ever been emotionally or physically abused?_____
❒ Was it by someone important to you?_____
❒ Is any part of your body numb?_____
❒ Have you ever had any seizures or convulsions?_____
❒ Have you ever had a stroke or severe head injury?_____
❒ Do you frequently feel anxious or stressed?_____
❒ Have you ever attempted suicide?_____
❒ Has anyone in your family died of suicide?_____

DIGESTIVE

❒ Are you troubled by heartburn or indigestion?_____
❒ Is it difficult or painful for you to swallow?_____
❒ Are your bowel movements bloody or black?_____
❒ Have you had any bleeding from your rectum? _____
❒ Are you having diarrhea or constipation?_____

Head Eyes Ears Nose & Throat: HEENT

❒ Do you have frequent headaches?_____
❒ Do you have poor vision?_____
❒ Do you have poor hearing?_____
❒ Do you have poor sense of smell?_____
❒ Do you have problems with your mouth or teeth?_____

RESPIRATORY

❒ Do you have wheezing, cough or shortness of breath?_____
❒ Are you bothered by hay fever?_____
❒ Do you snore or do others say that you snore?_____

FOR WOMEN ONLY

❒ When was the first day of your last menstrual period?_____
❒ Are your periods regular?_____
❒ Have you had any recent vaginal discharge or itching?_____
❒ Have you noticed any lumps or swelling in your breasts?_____
❒ How many times have you been pregnant____#
Miscarriages___#, Abortions___#, at ages:_____
Children living _____#?

Patient Signature:_____Date:_____

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Name:	DOB:	Date:

During the past 2 weeks have you:	Not at all	Several Days	More than half the days	Nearly every day
Lost interest or had less pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
**IF THE FIRST 2 ANSWERS ARE (0) THEN THE FOLLOWING QUESTIONS ARE OPTIONAL				
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself— or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Cr the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
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

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Annual Screening for Non-Medical Needs

Only answer those questions that apply
Otherwise leave questionnaire blank

1. In the last 12 months, did you ever eat less than you feel you should because there wasn't enough money for food?	YES
2. In the last 12 months, has the electric, gas, or water company threatened to shut off the services in your home due to inability to pay?	YES
3. Are you worried that in the next 2 months you may not have stable housing?	YES
4. Do problems with child care make it difficult for you to work or study?	YES
5. In the last 12 months, have you needed to see a doctor, but could not because of cost?	YES
6. In the last 12 months, have you ever had to go without health care because you didn't have a way to get there?	YES
7. Do you ever need help reading patient education or other patient materials and information provided?	YES
8. I often feel that I lack companionship?	YES
9. Are any of your needs urgent? For example: I don't have food tonight or I don't have a place to sleep tonight.	YES
10. If you checked YES to any questions above, would you like to receive assistance with any of these needs?	YES

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A wellness exam is a type of preventative care. Preventative healthcare focuses on maintaining wellness and stopping health problems before they occur. Instead of waiting until you have a health issue, you visit your physician to make sure that you're still in good health, or to catch health problems in early stages.

Wellness visits or wellness exams are typically annual, and are separate from other medical visits related to illness (including chronic illness) or injury.
While wellness exams are usually covered by insurance, your insurance might not cover all expenses involved with the visit, such as labs or tests. Most insurance plans pay for one wellness exam each year. Insurance plans and coverage vary, so be sure to check with your policy.

What may be included in a wellness exam?

Wellness visits basically provide your doctor with a status update on your overall health. They can help guide you to make choices that promote better health, and they can catch health problems early.
These visits may include:

- A physical examination (excluding Medicare Wellness Visits)
- Checking your vitals
- Checking BMI
- Examination of personal and family medical histories
- Discussion of current lifestyle and health choices
- Screenings
- Shots and immunizations
- Establishing a plan for your health

During your wellness exam you may receive screening for cholesterol, blood pressure, diabetes, mammogram, pap test, osteoporosis, or STDs. Your doctor may ask you about current stress, physical activity, diet, or drug use such as tobacco and alcohol. Much of the exam is discussion about ways to improve overall health through lifestyle and healthy decision making.

What is NOT included in a wellness exam?

- **Sick visits** If your time with your doctor involves a discussion of an illness or symptoms, from an infection to abdominal pain, and your doctor recommends care or a treatment plan, you will be charged a copay and/or a deductible.
- **Chronic illnesses** Your insurance for your annual wellness visit does not cover any discussion, treatment or prescription of medications for chronic illnesses or conditions, such as high blood pressure, high cholesterol or diabetes.
- **Any other medical problems or complaints**

You may decide to schedule a separate appointment to discuss topics that are not covered under your insurance plan in a wellness exam. But if you would prefer to avoid scheduling another appointment, we would be happy to address any additional health needs at the same time as your wellness visit. **In this instance, you will be charged a copay and/or a deductible.**

In, advance of your appointment, we encourage you to consult with your insurance provider if you have questions or concerns about your coverage.

Signature_____Date_____

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Acknowledgment and receipt of patient's rights and responsibilities

Aloha Patient,

Welcome and thank you for choosing our practice. We are committed to providing you with the best medical care based on your health needs. Our hope is that we can form a partnership to keep your whole self as healthy as possible, no matter what your current state of health.

Your commitment to my patient-centered medical home practice will provide you with an expanded type of care. We will work with both you and other health care providers as a team to take care of you. As your care team, we will involve you in the decisions about your health and health care, and thus be able to develop a stronger relationship with you.

Please review the lists of our roles and responsibilities as Patient and Provider attached.

We look forward to working with you as your primary care provider(s) in your patient-centered medical home.

_____	_____	_____
Patient Signature	Printed Name	Date
_____	_____	_____
Parent/Guardian Signature	Parent/Guardian Printed Name	Date

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ACKNOWLEDGMENT OF RECEIPT OF NOTICES OF PRIVACY PRACTICES

I, (print name) _____, have received a copy of Hawaii Family Physicians' notices of privacy practices. (**policy can also be viewed online at website**)

I understand that my immunizations are shared with HI State Immunization Registry to keep your /your child's record up to date. This helps you have all the vaccines need for school, medical care, travel, etc. An immunization record can be printed out for you. I can opt out of this by requesting an "opt-out form".

Patient's Signature: _____ Date _____

CONSENT TO SHARE PRIVATE INFORMATION

This consent will remain in affect until revoked by me in writing

I, (print name) _____, have read and understand Hawaii Family Physicians Privacy Practices and Policies. I hereby grant consent to Hawaii Family Physicians, its physicians and personnel to discuss issues and matters in regards to my treatment (diagnosis, testing), account status and/or appointments with the below named individuals. ***Please include emergency contact if appropriate.**

_____	_____	_____
(Print Name of Individual)	(Relationship to me)	(Phone)
_____	_____	_____
(Print Name of Individual)	(Relationship to me)	(Phone)

_____ _____

Patient/Guardian Signature Date

Optional: **This consent is hereby revoked on this _____ day of _____, 20 ____ by _____

For Staff only

(***Check one*** *if patient does not sign.)* We attempted to obtain written acknowledgment of the receipt of our notice of privacy practices but acknowledgment could not be obtained because:_____ Individual refused to sign, ____ Communication barriers prohibit patient to sign this acknowledgment, _____ An emergency situation prevented us form obtaining this acknowledgment, _____Patient requested HI Immunization Registry Opt out form _____ Other (please specify:) _____

Witness /sign name and date at bottom of page & scan into patient's chart.

Witness to patient's signature:

_____ _____

Employee Name Date

HAWAI'I ADVANCE HEALTH CARE DIRECTIVE

My name is: _____

Last First Middle initial Date of Birth Date

PART 1: HEALTH CARE POWER OF ATTORNEY – DESIGNATION OF AGENT:

I designate the following individual as my agent to make health care decisions for me:

Name and relationship of individual designated as health care agent

Street Address City State Zip

Home Phone Cell Phone E-mail

If I revoke my agent's authority or if my agent is not willing, able, or reasonably available to make decisions for me, I designate the following individual as my alternate agent:

Name and relationship of individual designated as health care agent

Street Address City State Zip

Home Phone Cell Phone E-mail

AGENT'S AUTHORITY AND OBLIGATION:

My healthcare agent should make decisions as I have instructed in Part 2 of this form or as I may otherwise provide orally or in writing. If there are decisions for which I have not provided instructions, I want my agent to make such decisions as I would have chosen to do, basing them on my values, goals, and preferences rather than those of my agent. If a guardian of my person needs to be appointed for me by a court, I nominate my agent.

WHEN AGENT'S AUTHORITY BECOMES EFFECTIVE:

My agent's authority becomes effective when my primary physician determines that I am unable to make my own health care decisions unless I mark the following box.

__ ☐ If I mark this box, my agent's authority to make health care decisions for me takes effect immediately. However, I always retain the right to make my own decisions about my health care. I can revoke this authority at any time as long as I have mental capacity.

PART 2: INDIVIDUAL INSTRUCTIONS (You may modify or strike through anything with which you do not agree. Initial and date any modifications.)

A. END OF LIFE DECISIONS

- If I have an incurable and irreversible condition that will result in my death within a relatively short time, OR
- If I have lost the ability to communicate my wishes regarding my health care and it is unlikely that I will ever recover that ability, OR
- If the likely risks and burdens of treatment would outweigh the expected benefits.

THEN I direct that my health-care providers and others involved in my care provide, withhold, or withdraw treatment in accordance with the choice I have marked below: Check only one of the following boxes. You may also initial your selection.

__ ☐ I want to stop or withhold medical treatment that would prolong my life.

OR

__ ☐ I want medical treatment that would prolong my life as long as possible within the limits of generally accepted health care standards.

YOUR NAME: _____

Print Your Full Name Date of Birth Date

PART 2: INDIVIDUAL INSTRUCTIONS (CONTINUED) (You may modify or strike through anything with which you do not agree. Initial and date any modifications.)

B. ARTIFICIAL NUTRITION AND HYDRATION - FOOD AND FLUIDS:
Artificial nutrition and hydration must be provided, withheld or withdrawn in accordance with the choice I have made in the preceding paragraph A unless I mark the following box.

__ ☐ If I mark this box, artificial nutrition and hydration must be provided under all circumstances as long as it is within the limits of generally accepted healthcare standards.

C. RELIEF FROM PAIN:

__ ☐ If I mark this box, I choose treatment to alleviate pain or discomfort even if it might hasten my death.

D. OTHER

__ ☐ If I mark this box, the additional instructions or information I have attached are to be incorporated into my care. (Sign and date each added page and attach to this form.)

E. WHAT IS IMPORTANT TO ME: (Optional. Add additional sheets if needed.) The things that I value and that make life worth living to me are: (examples: gardening, walking my pet, shopping, participating in family gatherings, attending church or temple):

☐ I have attached _____ additional sheet/s

My thoughts about when I would not want my life prolonged by medical treatment (examples include: If I no longer have the mental capacity to make my own decisions, if I have lost all ability to communicate, if I can no longer safely swallow, etc):

☐ I have attached _____ additional sheet/s

YOUR NAME: (Please sign in front of witnesses or notary public)

Print Your Full Name | Your Signature | Date of Birth | Date

WITNESSES: CHOOSE EITHER OPTION 1 OR 2, NOT BOTH.

Important: Witnesses cannot be your health care agent, a health care provider or an employee of a health care facility. One witness cannot be a relative or have inheritance rights.

OPTION 1: WITNESSES

I (Witness 1) declare that the person completing this advance health care directive is personally known to me, that she/he signed or acknowledged this power of attorney in my presence and appears to be of sound mind and under no undue influence. I am not related by blood, marriage, or adoption, and to the best of my knowledge I am not entitled to any part of her/his estate. I am not the person appointed as agent by this document, and I am not a health-care provider, nor an employee of a health-care provider or facility.

Witness #1 Print Name | Witness Signature | Date

Street Address | City | State | Zip

I (Witness 2) declare that the person completing this advance health care directive is personally known to me, that she/he signed or acknowledged this power of attorney in my presence and appears to be of sound mind and under no undue influence. I am not the person appointed as agent by this document, and I am not a health-care provider, nor an employee of a health-care provider or facility.

Witness #2 Print Name | Witness Signature | Date

Street Address | City | State | Zip

OPTION 2: NOTARY PUBLIC

State of Hawai'i,
(City and) County of _____ } ss.

On this _____ day of _____, in the year _____, before me, _____, (insert name of notary public) appeared _____, personally known to me (or proved to me on the basis of satisfactory evidence) to be the person whose name is subscribed to this ___ -page Hawai'i Advance Health Care Directive dated on _____, in the _____Judicial Circuit of the State of Hawai'i, and acknowledged that he/she executed the same as his/her free act and deed.

_____
Signature of Notary Public

My Commission Expires:_____

A copy has the same effect as the original.
www.kokuamau.org/resources/advance-directives
Developed by the Executive Office on Aging and
Kōkua Mau - Hawai'i Hospice and Palliative Care Organization

Place Notary Seal or Stamp Above

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Name:	DOB:

Aloha,

Please play your part in helping us to be more "GREEN"!

We are requesting ALL our patients to join our Patient Portal for ease of communication. The patient portal is compliant with privacy laws and protected by your password and verification.

This would require you to allow us to utilize the email address and mobile number provided to us in your new patient registration form. A link will be sent to your email address where you can sign up and receive login access to the patient portal. This is our preferred method for communication. With this access you'll be able to request lab results, request refills and appointments, and communicate with your Provider regarding questions or inquiries. This would replace most phone calls to our office and help us track your requests as all communication is automatically stored in your electronic medical record. *Each family member will need to have a separate email address for portal access.

EMAIL ADDRESS: _____

Note: Inquiries for refills should be directed to your pharmacy as they will have the most accurate information in regards to your medication refills still available to you. The pharmacy will then communicate the request to us automatically through electronic communication again allowing requests to be stored automatically.

Soon you will be able to schedule your own appointments on the patient portal as well! This new feature is coming soon.

If this is agreeable to you, please sign and date below:

_____ _____

Patient or Guardian Signature *Date*

Thank you for your interest in being a patient of Hawaii Family Physicians!

Hawaii Family Physicians

75-5870 Walua Rd. #200 Kailua-Kona, HI 96740 p:808-323-3107 f:808-323-0012

David Arthurs, DO Beth Catanzaro, MD Nathan King, MD John Littleton, PAC Marie Thomas, PAC Hannah Montanye, PAC

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Legal Name: _____Date of Birth: _____

Previous Name: _____Phone Number: _____

Address: _____

City _____ State_____ Zip _____

I request a copy of my medical record as held by:

✓ **Office of:** _____

Fax Number: _____

Please release the following records:

✓ Vaccination and Medication History

✓ Cancer screenings: ✔Colorectal (colonoscopy) ✔Cervical (pap) ✔Breast (mammo)

✓ Labs and/or Pathology to support cancer screening findings

Further records to be requested later as indicated by Medical Provider

✓ **Please release records by <u>Secure Fax</u> to: Hawaii Family Physicians: <u>808-323-0012</u>**

or ❒ Mail to: 75-5870 Walua Rd. #200
Kailua-Kona, HI 96740

Other: _____

❒ **Records to be released to office of:** _____

Fax number or address: _____

I, the undersigned, understand that by signing below I am authorizing the release of any medical information regarding the above as might be necessary to provide and administer optimum, continuing health care and that this may include information relative to substance abuse, HIV status, sexually transmitted diseases, mental conditions, and/or other confidential information.

I agree to pay this charge in full at the time I receive the copy of the record if for personal records. I understand that, unless otherwise provided by law the charge for this record is a minimum of $10.00 plus $0.25 per page. I understand I have the right to revoke this Authorization at any time. This Authorization will expire on the earlier of _____ (date) or two years after my death.

Signature: _____Date _____

Relationship if other than patient _____

Witness _____ Date _____

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PATIENT'S RIGHTS AND RESPONSIBILITIES

Good health depends on a cooperative relationship between you and your doctor/medical provider

As a patient you have a right to:

- Be treated with dignity and respect.
- Get timely attention to your health care needs.
- Get complete and current information concerning diagnosis, treatment, and expected outcome in terms you can reasonably understand.
- Get information you need to give informed consent before treatment or any surgery.
- Make decisions about your medical treatment plan with your doctor.
- Know what is expected of you to comply with your medical treatment plan.
- Have your health information kept confidential.
- Get accurate information about the costs of your care.

As a patient you have the responsibility to:

- **Keep appointments. Arrive early to check in before scheduled time with doctor.**
- Let us know at least 24 hours (one business day) in advance if you cannot make your appointment or will be late to avoid $75 - $100 'missed appointment' fees. In the event of 3 no-shows and/or short notice (*less than 24-hour*) cancellation, ***you will likely be discharged from our practice and will have to find another primary care provider***.
- Give your doctor accurate and complete information about your health condition and past medical history. Let us know when you see other health care providers so we can coordinate the best care for you.
- Contact us before going to the emergency room if possible. Come in for follow up within 3 days after a visit to ER or a hospital stay.
- Ask questions, as appropriate, to learn about your conditions and what you can do to stay as healthy as possible and understand your medical care, treatment, and services provided;
- Be a full partner with us in your care. Follow agreed upon treatment plans.
- Live a healthy lifestyle and lower your health risks. Take medications as prescribed. Contact us after hours only if an urgent health problem. Come to each visit with updates on medications, dietary supplements, or remedies.
- Treat all staff members with respect; agree that all health care providers in your care team will receive all information related to your health care.
- Conduct yourself in a manner consistent with the office environment – respecting the needs of other patients/visitors;
- Let us know if you are dissatisfied with services. Give us feedback to help us improve our care for you.
- Login to your patient portal and use it to communicate with us re: your new medication, health concerns, etc.

As a patient, your financial responsibilities are:

- To give us accurate and complete address, telephone, family and insurance information and let us know immediately when there are any changes;
- Bring in your insurance card each time you come to the office for services if you are insured;
- Pay all co-payments and out-of-pocket payments at the time of your visit if you are insured;
- Pay in full at the time of each visit if you are self-pay.
- If there is ever a balance, be responsible to pay your bill/statement in full and on time or call our Billing dept.
- Learn about your health insurance coverage and contact your insurance plan if you have any questions about your coverage. Follow all insurance company guidelines about how to access services.
- I agree to pay a $75.00 no show fee if I miss my appointment without canceling, and $100 for the 2nd appointment missed. I agree to give 24 hours/1 business day notice to change my appointment.

Provider / Staff Roles and Responsibilities

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- Learn about you, your family, life situation, and health goals and preferences.
- Treat any short-term illness, long-term chronic disease, and help improve your overall health.
- Keep you up to date on all your vaccines and preventative screening tests and notify you of test results in a timely manner.
- Connect you with other members of your care team (specialists, etc.) and coordinate your care with them as your health needs change.
- A staff member will be available to you after hours by phone 808- 345-7745 for you to leave a message re: your urgent needs.
- Communicate clearly with you so you understand your condition(s) and all your options.
- Listen to your questions and feelings and respond promptly to you in a way you understand.
- Help you make the best decisions for your care.
- Give you information about classes, support groups, or other services that can help you learn more about your conditions and stay healthy.

Phone calls

We will respond to non-urgent phone calls the same day or the following morning.
If you reach our office during normal business hours and the phones are busy, we check messages several times per day and respond as soon as we have an answer from the medical assistant or doctor for you. Our goal is to return your call the same morning or afternoon of your call. If you call us after normal business hours, we will return your call the next morning.

Prescription refill requests

No new medications are prescribed without an appointment. Prescription refill requests are to be submitted 7 days before your prescription runs out or expires. We will fill these requests (by phone, fax or e-prescribing) within one week of receiving your request if we determine no appointment is necessary. We can't refill medications if you have not seen your doctor during the past year. Some medications require more frequent appointments.

Scheduling with your preferred medical provider

When scheduling an appointment, we will ask you: who is your primary care provider? You will be scheduled with your primary care provider whenever possible. If your visit is urgent and your PCP's slots have been filled, or your provider is out of town /not working that day, we will offer you an appointment with the other providers in the office.

Messages

You may call our office and leave a message with one of our receptionists. Be as specific as you can about what you need or your concern. If it is not something we can handle on the phone, you will be asked to schedule an appointment and discuss it with your provider. You may also contact us via your patient portal, (i.e. to schedule appointments, request labs, etc.)

Non English Speaker?

Two of our providers speak Spanish. We have Patient Information packets in Spanish available. Please request one if needed. If an interpreter is needed for your visit, please either bring one or give us advanced notice that you need one.

No Insurance?

Please talk to our billing coordinator to get information about health resources and or applying for Quest. We do offer discounts for self-pay patients who have a financial need who pay *in full at the time of service*.

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NOTICE OF PRIVACY PRACTICES (Medical)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health Information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health Information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment. payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of this would include a physical examination, referral to a specialist, etc.
- Payment means such activities as obtaining reimbursement for services, confirming coverage billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review,

We may also create and distribute de-indentified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by ***presenting a written request to our office staff.***

- The right to give access or request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to receive a copy your protected health Information. (Note: a fee is charged for copies of your record)
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request. (We give this notice to all new patients.
- We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of March 1, 2005 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. Also visit our website: www.hawaiifamilyphysicians.com

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information. For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, S. W. Washington, D.C. 20201 Phone (202) 619-0257 Toll Free: 1 877-696-6775