

PATIENT DEMOGRAPHIC FORM
(THIS FORM MUST BE UPDATED EVERY 6 MONTHS OR WHEN ANY INFORMATION CHANGES)

PATIENT	PATIENT NAME (LAST, FIRST, MIDDLE)			ALSO KNOWN AS / MAIDEN NAME			SOCIAL SECURITY NUMBER		
	DATE OF BIRTH		AGE	SEX <input type="checkbox"/> M <input type="checkbox"/> F	MARTIAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> LEGALLY SEPARATED <input type="checkbox"/> WIDOWED <input type="checkbox"/> LIFE PARTNER <input type="checkbox"/> NEVER MARRIED				
	STREET ADDRESS (NO PO BOX)				CITY, STATE			ZIP CODE	
	MAILING ADDRESS (IF DIFFERENT FROM ABOVE, PO BOX)				CITY, STATE			ZIP CODE	
	DAY PHONE <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL			EVENING PHONE <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL			ARE YOU VISITING? <input type="checkbox"/> NO <input type="checkbox"/> YES, IF YES PLEASE CONTINUE BELOW		
	WHERE ARE YOU STAYING? <input type="checkbox"/> HOTEL <input type="checkbox"/> RESIDENTIAL PLEASE PROVIDE THE NAME OF HOTEL OR RESIDENTIAL ADDRESS BELOW						DATE YOU ARE LEAVING?		
	EMPLOYER (IF STUDENT, NAME OF SCHOOL)			EMPLOYER ADDRESS			CITY, STATE		ZIP CODE
	EMPLOYER PHONE INCLUDING EXTENSION			EMPLOYMENT STATUS <input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME <input type="checkbox"/> OTHER			OCCUPATION: <input type="checkbox"/> STUDENT		
	PRIMARY CARE PHYSICIAN				REFERRING PHYSICIAN (IF OTHER THAN YOUR PRIMARY CARE PHYSICIAN)				
	HAVE YOU BEEN TREATED AT KAHALA URGENT CARE PRIOR TO TODAY'S VISIT? <input type="checkbox"/> YES <input type="checkbox"/> NO - IF NO, PLEASE ANSWER THE QUESTION BELOW HOW DID YOU HEAR ABOUT US? <input type="checkbox"/> FAMILY MEMBER <input type="checkbox"/> FRIEND <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> YELLOW PAGES <input type="checkbox"/> WEBSITE/INTERNET <input type="checkbox"/> EMPLOYER <input type="checkbox"/> INSURANCE <input type="checkbox"/> MAIL <input type="checkbox"/> NEWS <input type="checkbox"/> TELEVISION <input type="checkbox"/> OTHER, PLEASE SPECIFY								

PARENT/LEGAL GUARDIAN	IF THE PATIENT IS UNDER THE AGE OF 18, THE PARENT OR LEGAL GUARDIAN WHO BROUGHT IN THE PATIENT MUST FILL THIS SECTION OUT											
	RELATIONSHIP TO PATIENT		GUARANTOR NAME			SOCIAL SECURITY NUMBER			DATE OF BIRTH		AGE	SEX <input type="checkbox"/> M <input type="checkbox"/> F
	ADDRESS				CITY, STATE			ZIP CODE				
	PHONE <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL			EVENING PHONE <input type="checkbox"/> HOME <input type="checkbox"/> WORK <input type="checkbox"/> CELL			EMPLOYER PHONE					
	EMPLOYER					OCCUPATION						

EMERGENCY CONTACT				NEXT OF KIN			
NAME		RELATIONSHIP TO PATIENT		NAME		RELATIONSHIP TO PATIENT	
HOME PHONE	EMPLOYER PHONE	CELL PHONE		HOME PHONE	EMPLOYER PHONE	CELL PHONE	

PRIMARY INSURANCE				SECONDARY INSURANCE				
INSURANCE COMPANY NAME								
SUBSCRIBER'S NAME		<input type="checkbox"/> SAME AS ABOVE	RELATIONSHIP TO PATIENT			SUBSCRIBER'S NAME		RELATIONSHIP TO PATIENT
SUBSCRIBER'S SOCIAL SECURITY NO.		SUBSCRIBER'S DATE OF BIRTH			SUBSCRIBER'S SOCIAL SECURITY NO.		SUBSCRIBER'S DATE OF BIRTH	
SUBSCRIBER'S ADDRESS				SUBSCRIBER'S ADDRESS				
SUBSCRIBER'S CITY, STATE			ZIP CODE		SUBSCRIBER'S CITY, STATE			ZIP CODE
PHONE		EMPLOYER			PHONE		EMPLOYER	

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES – Details of your rights and how your medical information will be used and disclosed by Kahala Urgent Care is set forth in the NOTICE OF PRIVACY PRACTICES. A copy has been given to you and is posted in the clinic.
I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered. Medicare rules and Kahala Urgent Care insurance agreements may affect patient responsibility for the account. **I have completed the above questions and certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my insurance status or any of the above information.** I request that payment of authorized medical benefits, if any, be made to Kahala Urgent Care on my behalf for any unpaid services rendered by Kahala Urgent Care physicians.
I authorize the release of medical information to the health plan indicated for information requested by the health plan to determine the payment of medical benefits. The information authorized for release may include information about communicable or non-communicable disease, mental health, and substance or alcohol abuse.
I acknowledge receipt of the NOTICE OF PRIVACY PRACTICES.

SIGNATURE OF PATIENT (IF PATIENT IS A MINOR, SIGNATURE OF PARENT OR LEGAL GUARDIAN) _____ DATE _____

OFFICE USE ONLY:

I have copied Government Issued ID Insurance Cards front and back I have verified that the above information is completely filled out. KUC staff initials _____

HIPAA AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

If patient is under the age of 18, parent or guardian must fill out the information below

I DO NOT AUTHORIZE Kahala Urgent Care to release any of my health information, which also includes financial obligations, to anyone, including my family members. (If patient is under 18, parent or legal guardian is not authorizing his/her child's health information and we will only speak to the parent or legal guardian who filled out and signed this form.)

I DO AUTHORIZE AND REQUEST that Kahala Urgent Care to release my health information to:

My primary care physician, (please write first and last name): _____

And or

Name: _____ Relation to patient: _____

Address: Same as patient or if different: _____

Contact Phone number: _____

Which will include the following: (please check below)

All of my health information, which includes financial obligations

Healthcare information relating to the following treatment, condition, or dates: _____

The information below, gives you the option whether or not you would like to disclose this information or not.

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

Yes No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

Yes No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

RIGHT TO REVOKE: I may revoke this authorization in writing at any time. I understand my revocation will NOT affect my disclosure that occurred before Kahala Urgent Care received notice of my written revocation. If I do not revoke it, this authorization will expire on the following date or event _____ **(IF DATE IS NOT SPECIFIED, THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM THE DATE OF SIGNATURE**

BELOW.) To revoke, I will write a letter which includes my name, address, best contact phone number, and my statement that I want to discontinue the release of information, and the name of the people/entities to which I no longer want to have access to my information. I understand that if my letter is not signed **AND** dated, Kahala Urgent Care will not be able to honor it. This letter can be mailed to Kahala Urgent Care at 4218 Waialae Ave Box 14, Honolulu, HI 96816, **Please keep a copy of your letter for your records.**

Failure to complete above will indicate that I am not authorizing disclosure of my health information to any persons/entities at this time. I will notify Kahala Urgent Care in writing if I should change my decision.

Signature required: _____

Date required: _____

If patient is under the age of 18:

Parent/Legal Guardian's Name: _____

Relationship to patient: _____

THIRD PARTY LIABILITY INJURY/ILLNESS REPORT/QUESTIONNAIRE

SECTION A: What does TPL stand for?

TPL stands for **third party liability** and is a term that means the patient has been injured or became ill and the injury or illness was caused by someone else – a third party. Some common examples of TPL are injuries caused by automobile accidents or by circumstances at the patient’s workplace. Other accidents may occur on a school playground or in a retail establishment. Your personal medical insurance plans do not provide coverage for services performed in connection with an injury or illness for which someone else is financially responsible. Claims for these services should be billed to the appropriate motor vehicle, worker’s compensation or liability insurance carrier.

When it’s not TPL? Sometimes accidents happen and there is no one who is liable to pay for the services needed to treat the patient’s injury. When this occurs, providers may bill the patient’s personal medical insurance plan. If there is no TPL, claims must be billed to your personal medical insurance plan in a manner that explains how and where the patient was injured. If this information is not received, payment may be delayed while your personal medical insurance carrier researches the matter. This research may involve sending the patient forms to complete or asking the provider how the patient was injured.

SECTION B: **PLEASE COMPLETE THIS SECTION**

In order to determine benefits for your claim(s), Kahala Urgent Care requires the following additional information for services that may be the result of an injury or illness. **ALL questions require a response.** Please note failure to respond may result in a delay or denial of your claim.

Patient’s Name: _____ Date of birth: _____

Date of injury/illness: _____

Please describe how your accident happened: _____

- Where did this occur? WORK, if you marked work proceed to Section I
 AUTOMOBILE, if you marked automobile proceed to Section II
 OTHER (please explain) _____, if you marked other proceed to Section III

Work Related Injury, Please complete the following section:

1. Is this your first/initial visit for this injury/illness? YES NO
If NO, Where else where you treated? _____ Date you were treated? _____
2. Have you filed for Workers’ Compensation YES NO, if no please explain: _____
3. Who is your employer? _____ Employer’s Phone _____
Employer’s address (street, city, state, zip code) _____
Name of your Supervisor _____ Your Occupation _____
4. What insurance company covers your Workers’ Compensation? _____

Please provide us with the adjuster’s name, phone number and your claim number for your injury/illness

Claim number: _____ Adjuster’s name: _____ Phone: _____

If you were treated by someone else (excluding the Emergency Room) for the date of injury/illness stated above, Kahala Urgent Care is not allowed to treat you for that injury/illness. You must go back to whom you have been treated by previously or contact your adjuster for further information. If you are not sure who your insurance company is, we ask that you notify us with this information within four weeks from your first visit.

Automobile Related Injury, Please complete the following section:

1. Please check one: Where you a passenger? driver? pedestrian?

2. If you were a **passenger** or a **driver** please indicate:

The owner of the vehicle: _____ Phone: _____

Address (Street, City, State, Zip Code): _____

The name of the company which insured the vehicle you were in: _____

Claim number: _____ Adjuster's name: _____ Phone: _____

3. If you were a **pedestrian**, please indicate:

The name of the owner of the vehicle which struck you: _____ Phone: _____

Address (Street, City, State, Zip Code): _____

The name of the company which insured that vehicle: _____

Claim number: _____ Adjuster's name: _____ Phone: _____

Kahala Urgent Care is only allowed to accept motor vehicle accidents that occurred in the State of Hawaii. If your injury/illness happened somewhere other than the State of Hawaii, Please contact your adjuster for more information.

Other:

Do you believe another person(s) is or may be responsible for your injury or illness? YES NO

If you answered yes, please speak to the receptionist or any of the medical staff. Kahala Urgent Care is not allowed to participate with any other third party liability carriers other than automobile and worker's compensation. If you believe that someone else is responsible for your injury/illness and it is not related to an automobile or work accident you will be asked to pay for your visit at the time of service. You will be given an itemized receipt for you to bill the appropriate person(s) you believe are responsible.

PLEASE READ THE FOLLOWING CAREFULLY

By signing below, I certify that the above information is true and correct to the best of my knowledge

Signature _____

Date: _____

OFFICE USE ONLY:

TPL is related to WORK AUTOMOBILE OTHER, Please specify _____

I have verified that this form was filled out completely KUC Initials _____



Payment and Insurance Financial Policy

Thank you for allowing Kahala Urgent Care to be your provider of choice. We are committed to providing you with the highest quality affordable health care. Some of our patients have had questions regarding their insurance and their individual payment responsibilities for the services we provide. We have developed this policy to answer those questions and to provide some basic information for any financial decisions that may arise during the course of your care. Please read this policy and feel free to ask any questions you may have. We ask that you also sign below to acknowledge your understanding and acceptance. A copy will be provided to you upon your request.

- 1. FEE FOR SERVICE:** If you do not have insurance, you may still be seen at Kahala Urgent Care. However, you will be responsible for payment of all charges incurred. Payment will be due in full at the time of service; and we are happy to extend a 25% discount for the office visit portion of your care when payment is made in full at time of service.
- 2. INSURANCE:** We participate with Medicare and with most other health insurance plans such as, but not limited, to HMSA, HMAA, MDX, Tricare West, Tricare for Life, UHA, United Health Care, Aetna, Cigna, HMA, and some, but not all, HMOs. If your insurance is a HMO it may require you to obtain a written referral from your primary doctor before we can see you. If you are insured under a plan we do not participate with, payment in full will be expected for your visit at the time services are rendered. You will then be responsible for submitting your own claim to your insurance carrier for reimbursement. Understanding your insurance benefits is your responsibility. If you are unsure about your benefits or participation with your plan, please call the number on the back of your insurance card.
- 3. PROOF of INSURANCE:** All patients must complete our patient information form as well as any other required forms prior to being seen by us. If you are insured by a plan we participate with, you must have a valid insurance card member ID and a valid State ID, driver's license, or passport, which we can photocopy. Insurance carriers require us to ask you for your social security number so that we may verify your coverage. If you are unable to produce these IDs or we are unable to verify your identity or coverage, we will need to collect payment in full at the time of your visit.
- 4. CO-PAYMENTS AND DEDUCTIBLES:** Your medical insurance carrier requires that you pay a co-payment amount for your medical visits as well as satisfy a deductible amount before it will pay for your health care. It is our practice policy that co-payments and any deductible amounts which may apply to your care at our facility be collected by us at the time of your visit. Depending on your insurance carrier, we may not have sufficient information to determine the total amount of your co-payment(s), co-insurance, and/or deductible at the time of your visit. We may therefore bill you at a later date for your patient payments. For your convenience, we accept Hawaii State personal checks, cash, Visa, MasterCard and Discover Card. A \$30 administrative fee as well as any bank fees incurred will be assessed for each check or electronic transaction denied by your bank for any reason.
- 5. NON-COVERED SERVICES:** Please be aware that some, and perhaps all, of the items or services you receive may not be a covered benefit under your insurance plan. Your insurance benefits are determined by the plan chosen by you and your employer and how much your employer pays for your coverage. It is your responsibility to contact your insurance company if you have any questions or concerns. It is also your responsibility to pay in full at the time of service for any non-covered items or services.
- 6. MEDICARE PATIENTS AND DURABLE MEDICAL EQUIPMENT (DME):** Beginning in 2011, Medicare will no longer pay for durable medical equipment (DME) obtained at a physician's office or clinic. Therefore, if you wish to obtain DME at the time of your visit such as, but not limited to, crutches, braces, and boots, you must fill out an ABN Medicare form and pay in full at time of service for your DME supplies. If you want Medicare to pay for your DME, we will provide you with a DME prescription which you can take to your preferred DME supplier. We will provide you with a list of suppliers upon request.
- 7. CLAIMS SUBMISSION:** If we are a participant with your plan, it is our policy to submit your claim to your insurance company. It is sometimes necessary for your insurance company, or our billing department, to contact you directly for information or assistance. It is your responsibility to comply with this request in a timely manner. Please understand that the balance of your account is your responsibility whether your insurance company pays your claim or not. It is in all parties' best interest to cooperate in this matter. We ask you to review all correspondence carefully and contact your insurance company or us immediately with questions or concerns. If we do not receive full payment from your insurance company within 45 days from the date of submission, the entire balance owed may become your responsibility.
- 8. COVERAGE CHANGES:** If your insurance changes, it is **YOUR** responsibility to notify us at the time of your visit so we can make the appropriate changes to assist you in receiving your maximum benefits. If you do not notify us at the time of your visit, we may not be able to properly bill your insurance company for your services and full payment for the services provided will be your responsibility.
- 9. NONPAYMENT:** As a courtesy, we will provide you with statements of your account. It is your responsibility to review these statements for accuracy and respond immediately to any and all requests for information and payment. If you have not received a statement from Kahala Urgent Care within 60 days of your visit, please call us to confirm your billing information. We are required by federal law to support all services rendered with proper documentation in your medical records. We can not alter a claim to obtain payment unless there has been a documentation error. If you discover an error, duplicate charge, or have any concerns about your bill, please contact our billing department (866-313-2444) immediately for investigation and proper corrective action. All outstanding balances are due upon receipt and become past due 30 days later. A 2% monthly service charge (24% per year) will be charged on accounts overdue past 60 days and accounts 90 days past due may be subject to collection action pursuant to the full extent of the law. Partial payments will not be accepted. Please understand that in the event that your account is referred to collections you will be responsible for any additional costs attributable to that action including, but not limited to, agency, attorney and court costs incurred and permitted by the laws governing these actions. Also be aware that you may be refused service in the future due to non-compliance.

- 10. ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:** We will enforce your privacy rights to the full extent of all local, state and federal laws and maintain the privacy of your personal health information. At your request, we will provide you with a Notice of Privacy Practice, which further describes this policy.
- 11. WORKMAN'S COMP:** If you have an injury which occurred while at work, or is potentially related to work, we will submit a claim on your behalf, and seek payment for your services, from your employer's workman's compensation insurance carrier. At the time of your visit, we will require the following information: date of your injury, your employer's name, address and phone number, name of your supervisor or person to contact regarding your injury, and the name of your employer's workman's compensation carrier. If you are not able to provide us with the name of the workman's compensation carrier at your first visit with us, we ask that you obtain this information and submit it to us within two weeks from the date of your first visit. If we do not receive this information, we will have to refuse further service related to your injury. You must inform your employer of your injury prior to being seen by us. If you are unable to inform your employer before you are seen, you will need to make sure you do so after you have been treated. If you file an injury report with your employer but do not inform your employer of your visit to Kahala Urgent Care, you will be responsible for the claim and we may refuse further service related to your injury. If you request that we submit a claim to your **medical** insurance carrier and your injury is determined to be work related, we cannot guarantee that your **medical** insurance carrier will pay for your visit. We will not be able to change our documentation once you have reported to Kahala Urgent Care staff that your visit was due to an injury that occurred at work or was related to work. If your claim is denied for any reason or if your employer fails to timely file your claim, you will be held responsible for the full payment for the services rendered. If you have been treated by another physician for your injury, other than an emergency room visit, before coming to Kahala Urgent Care, we will not be able to assume care for your injury. If your claim is rejected due to errors in the information you provided, you will be responsible for all charges.
- 12. NO-FAULT LAW:** If you were injured as a result of an automotive accident which occurred in Hawaii, we will seek payment for your services from the no-fault insurance carrier of the owner of the vehicle you were riding in, *regardless of who was at fault for the accident*. If you are the vehicle owner, you are required to give us a copy of your no-fault insurance card and your insurance claim number. If you were not the owner of the vehicle, you are required to give us a police report number as well as a copy of the police report within four weeks of the accident so we will know the name of the insurance carrier to seek payment from for your services. We will only bill your **medical** insurance carrier if the accident occurred in Hawaii, and you have a denial letter from the no-fault insurance carrier stating you have exhausted your no-fault allowances or stating you are not eligible for payments under no-fault law. When billing your **medical** insurance carrier, we are required by law to report on our claim submission that your injury was the result of an automotive accident. If your automotive related injury occurred more than a year before your visit, we may require proof that your no-fault coverage has not been exhausted before we submit your claim to your **medical** insurance carrier. If your claim is rejected due to errors in the information you provided, you will be responsible for all charges.
- 13. THIRD PARTY LIABILITY:** Injuries that did not occur at work or did not involve a motor vehicle, and were caused by a third party who you think should be responsible, will be considered third party injuries. Some examples of third party injuries are injuries that occur at stores, restaurants, or on sidewalks, and a third party may or may not be responsible, and/or liable. Kahala Urgent Care will not seek payment from the third party on your behalf. The cost of a visit due to an injury from a third party will be due in full at time of service. We will give you an itemized receipt to submit to the party you think is responsible for your injury for reimbursement.

Medicare / Medicaid / Tricare Patient's Certification: I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act or in connection with any other government program is correct. I authorize any holder of medical, or other information, about me to release to the Social Security Administration, other intermediaries, or carriers of the State any information needed to process a claim for this or any related service. I request that payment of authorized charges be made in my behalf directly to the facility for its charges and for any charges of physicians or other providers for whom the facility is authorized to bill in connection with its service.

Thank you for taking the time to review our financial policy. Please let us know if you have any questions or concerns.

A copy of our Financial Policy can be found on our website at www.kahalaurgentcare.com.

If you prefer a copy of the Financial Policy you signed, please notify the receptionist.

I have read, understand and agree to the guidelines outlined in this policy.

If you are under the age of 18, your parent or legal guardian must sign below:

Print your name

Sign your name

Today's Date

Relationship to the patient: _____

Witnessed by – Kahala Urgent Care Staff

Title/Position Held

Today's Date