Form D

Straub Occupational Health Services

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REGISTRATION DATA SHEET

Email completed Form D to Straub: Jennifer.oldershaw@straub.net and dora.sakata@straub.net

Patient please print legibly

Patient Name _____ _____ _____
First Middle Last

Birth date _____ Sex: (Circle One) Male / Female Age _____

Marital Status: (Circle One) Single Married Divorced

~~Social Security Number~~ Last 4 digits SS# _____ Race _____

Religion _____ Any Special Needs _____

Address Line 1 _____

Address Line 2 _____

City, State _____ Zip Code _____

Telephone _____ Work Phone _____ Cell Phone _____

Employer _____ Employment Status _____

Name of Personal Physician _____

EMERGENCY CONTACT INFORMATION

Contact Name #1 _____ Relationship _____
Telephone _____ Cell Phone _____

Contact Name #2 _____ Relationship _____
Telephone _____ Cell Phone _____

~~**INSURANCE INFORMATION**~~ (If available, Examination Costs are covered by your Company.)

Subscriber Name _____ Insurance Name _____

Policy Number _____ Effective Date _____

Relationship to Subscriber _____

TERMS AND CONDITION OF SERVICES

1. ***Consent for Treatment***

I consent to medical care and treatment at this medical facility. Accordingly, I consent to the procedures, which may be performed during my clinic visits or this hospitalization, including emergency treatment. I authorize and consent to any of the following: X-ray examinations, laboratory procedures, other diagnostic procedures, medical or surgical treatment, or other clinical and hospital services including the use of telemedicine, photography, videotaping or other audio and/or visual recording, as directed by my physician(s) or my physician's (s) assistants, which my physician(s) believes are advisable to evaluate, diagnose, or treat me or document findings, and to other services rendered under the general and special instructions of my physician(s).

I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that this facility has not made any guarantees to me as to the results of treatments or examinations. I am also aware that I should ask my physician any questions that I may have about my diagnosis, treatment, risks or complications, alternative forms of treatment, and/or anticipated results of treatment.

2. ***General Duty Nurses***

I understand it is the standard practice of this medical facility to provide general duty nursing care. This facility shall not be responsible to provide additional nursing care. If I need or desire additional nursing services, I will be responsible for obtaining and paying for such services.

3. ***Disclosure of Information for Payment Purposes***

I understand my medical information will be sent to my insurance carrier for billing purposes for any treatment I may receive at this medical facility including treatment for Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS), mental health diagnoses, and/or drug, alcohol or other substance abuse.

I understand according to Hawai'i law, I may choose to pay for services pertaining to HIV or AIDS treatment or any other services if I do not want my health information provided to my insurance company. I agree to notify this medical facility of my wishes regarding payments before these services are provided. I also understand that if I fail to pay for services, this information will be sent to my insurance company.

4. ***Information to Other Providers***

I understand that this facility may share my information electronically or on paper with other providers in the course of my treatment, and/or making arrangements for my continuing care, or upon request when seeking care from other providers. Examples of shared information may include, but are not limited to, mental health, cosmetic procedures, medications, and other past medical history. If I prefer that this medical facility not use or share my information, I may submit a written request for consideration per this facility's Notice of Privacy Practices.

5. ***Financial Responsibility***

I understand that I will receive a bill from this medical facility. The physician(s) may also bill me separately for their services provided to me while at this facility. I further understand not all physicians are employees of this medical facility. I understand and agree to pay for charges for services rendered and that I am obligated to pay for services in accordance with the regular rates and terms of this medical facility. This medical facility reserves the right to charge a Late Payment Fee and/or Returned Check Fee.

I understand that it is my responsibility to provide all applicable insurance information to this medical facility. I am aware that many insurances require preauthorization or certification, and I understand that I will be responsible for my hospital bill if I fail to provide complete and accurate information at the time of service or immediately following discharge.

If I do not want information regarding any services I receive shared with my insurance and/or choose to pay all charges myself, I will notify this medical facility prior to receiving services.

Should the account be referred to an attorney or collection agency for collections, I agree to pay any reasonable attorney's fee, collection expenses and interest at the statutory rate on all delinquent accounts, whether or not the account is referred to a collection agency.

6. ***Medicare Coverage (if applicable)***

I certify that the information I have been given in applying for payment under Medicare is correct. I authorize the Social Security Administration to release information about my Medicare effective dates and Medicare claim number to this medical facility. I authorize any holder of medical or related information about me to release my information needed to process this or a related Medicare claim to the Social Security Administration or its intermediaries. I request that payment of benefits be made on my behalf to this medical facility for any services provided to me by this medical facility.

7. ***Assignment of Benefits***
I hereby authorize assignment of my medical insurance benefits I am due to this medical facility for application to the bill for medical services and supplies I received. I further authorize this medical facility to receive direct payment from all such benefit payments. I agree to remain responsible and liable for payments of all amounts due to this medical facility and not received from my insurance carrier(s). I understand this medical facility is submitting claims on my behalf as a courtesy. I SHALL NOT REVOKE THIS ASSIGNMENT FOR ANY REASON.

8. ***Personal Valuables (in-patient only)***
To the extent that I am able to function without prosthetic devices (e.g., denture, eyeglasses, hearing aids, etc.), I am encouraged to send them and other valuables or personal property home while I am hospitalized. I will not hold this medical facility liable for loss of, or damage to, my personal property regardless of its nature or value.

9. ***Patient Rights and Responsibilities***
I acknowledge I have received my Rights and Responsibilities as a patient as well as information regarding non-discrimination and language access services.

10. ***In-Patient Directory Information Preference (initial)***
I understand this facility maintains a patient directory and may share information about my location or general condition to anyone who asks about me by name in accordance with my preferences, as indicated here. (Initial your preference)

_____FULL INFO – I agree to be listed in the patient directory

_____NO INFO – I do not want to be listed in the patient directory

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OUR USE of PHONE, TEXT and EMAIL
I understand by giving my phone number and/or email address, I am agreeing to receive texts and/or phone calls (including those that are autodialed, automated or pre-recorded) and emails from HPH and its affiliates. HPH and its affiliates may send information to or contact me at this number and/or email address in connection with my care, appointments and services provided or available to me. I also understand my consent is optional and standard text messaging and/or data rates may apply. Initial: _____

CELL PHONE NUMBER: _____ EMAIL ADDRESS: _____

MINORS OR INCAPACITATED PERSONS – This patient is:
☐ A minor _____ years of age.
☐ Incapacitated and unable to sign for the following reason(s): _____

I have read this consent and I am the patient, or the patient's duly authorized representative. On my own behalf (or on the behalf of the patient), I accept and agree to be bound by all these TERMS AND CONDITIONS OF SERVICES.

_____ _____ _____
PATIENT OR REPRESENTATIVE'S SIGNATURE **DATE** **TIME**

_____ SELF
PRINT NAME **REPRESENTATIVE'S RELATIONSHIP TO PATIENT**

REPRESENTATIVE: (Please describe your authority to act on behalf of the patient)

ACKNOWLEDGEMENT OF RECEIPT OF THIS MEDICAL FACILITY'S NOTICE OF PRIVACY PRACTICES

_____ (Initial) I have received a copy of this facility's NOTICE OF PRIVACY PRACTICES.

The patient or their duly authorized representative is: ☐ unable or ☐ unwilling to make this acknowledgement.

HAWAIʻI PACIFIC HEALTH | KAPIʻOLANI PALI MOMI STRAUB WILCOX

☐ Inpatient ☒ Outpatient ☐ Emergency Room