CHARLIE Y. SONIDO, M.D. INC. dba PRIMARY CARE CLINIC OF KAUA 3216 Elua St. Lihue Hi. 96766

New Patient Information:

PATIENT NAME: FIRST NAME: ____________ MIDDLE INITIAL: ___ LAST NAME: ____________

ADDRESS: ____

E MAIL ADDRESS: ____

PHONE # ________________ SEX: ______ BIRTHDATE: ____________

MARITAL STATUS ________ STUDENT STATUS: FULL TIME: ______ PART TIME: ______

SOCIAL SECURITY NO: ________________ REFERRED BY: ________________

EMPLOYER: ________________ PHONE #: (___) ________________

ADDRESS: ____

OCCUPATION: ____

EMERGENCY CONTACT: ________________ PHONE # (___) ________________

RELATIONSHIP: ________________ OCCUPATION: ________________

EMPLOYER: ________________ PHONE #: (___) ________________

RESPONSIBLE PARTY: ________________ PHONE #: (___) ________________

ADDRESS: ____

PRIMARY INSURANCE: ________________ POLICY NO: ________________

SUBSCRIBER: ________________ RELATIONSHIP: __________ BIRTHDATE: __________

OTHER INSURANCE: ________________ POLICY #: ________________

SUBSCRIBER: ________________ RELATIONSHIP: __________ BIRTHDATE: __________

INSURANCE AUTHORIZATION (PLEASE READ AND SIGN)

I hereby authorized my doctor to furnish information to insurance carriers or government agencies concerning my illness & treatments and I hereby assign to them all payments for medical services rendered to myself or my dependents. I understand I am responsible for any amount not covered by insurance.

If I am covered by Medicare, I authorized any holder of medical information about me to release to the Health care financing administration and its agents any information needed to determine these benefits or the benefits payable for related service.

PATIENT SIGNATURE: ________________________ DATE: ________________

Primary Care Clinic of Kauai
Compassionate, Competent, and Culturally-Sensitive Care

PERSONAL HEALTH HISTORY

Name:____ Date: __________________________________

BD: _______________________ Occupation: __________________ Religion: ___________________________

Social History:(include injuries) **Type** **Amount**

Alcohol: _________________________ _______________________ per day

Tobacco: _________________________ _______________________ per day

Special Diet: _________________________ _______________________

Medical History: Please list all medical problems you have had or currently have & the year or age onset.____

____

____

____

Medication: Please list all medication(vitamins, over the counter ,etc)you take with strength & frequency.____

____

____

____

Surgeries: Please list all **operations & dates** you have had.____

____

____

____

Allergies: Medications, food and others____

____

____

Family History: Please list all known medical problems ,such as stroke, heart disease, cancer, hypertension, etc.
If deceased: Father: ____
Mother:____
Siblings:____

Immunization: list the dates your most recent immunization **Hepatitis A** _________ _ **Hepatitis B**___________

Flu Vaccine__________ **Pneumonia Vaccine** _____________ **PPD** _________ **Others:**____________________

3216 Elua St.Lihue, Hawai'i 96766
Phone: (808) 246-3800
Fax: (808) 246-3801

AGREEMENT OF FINANCIAL RESPONSIBILITY

We are committed to proving you with the best possible care. The purpose of this form is to help out patients make an informed choice about whether or not they want to receive services items or laboratory testing, knowing that they may be responsible for services that do not meet their insurance carrier's benefit payment criteria.

Notice from the Provider to Patient

Your insurance carrier will only pay for services that meet the benefit payment criteria of their health plan. If you carrier determines that a particular service does not meet their benefits payment criteria they will deny payment for services, and you will be responsible for the bill.
Some plans require patients to obtain referrals and/or pre authorization for services at outside facilities. If your plan requires a referral and/or pre authorization and we are subsequently unable to obtain one from your provider or insurance carrier, you will be responsible for the bill

Beneficiary Agreement:
This agreement is between me,____, and the providers of Primary Care Clinic of Kauai dba CHARLIE Y. SONIDO MD. INC.

_____ I have been notified by my provider that he or she believes that, in my case, my insurance carrier will probably not pay for the services, items or laboratory test identified with today's visit.
_____ I have read and understand that all services provided today may not meet my insurance carrier criteria for benefit payment. Therefore I am fully aware that I am responsible for payment of all services associated with today's treatment.

I acknowledge my financial responsibility and accept the terms of this Financial Agreement with Primary Care Clinic of Kauai dba CHARLIE Y. SONIDO MD. INC.

____
Print Name of Beneficiary or Authorized Representative

____ ____________________
Signature of Beneficiary or Authorized Representative Date

____ ____________________
Signature of Clinic Representative Date

created by: amyloucaguinaldo04/28/2016

CHARLIE Y. SONIDO, M.D., INC.

AUTHORIZATION FOR USE OR RELEASE OF HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information and when we need your written authorization to do so. This form is for use when such authorization is required and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Name of Patient: ______________________________

Date of Birth: ____________________ SSN: ______________________________

I. My Authorization

I authorize the following using or disclosing party(ies):

Name	Relationship	Name	Relationship
________	________	________	________
________	________	________	________
________	________	________	________

to use or disclose the following health information.

☐ All of my health information

☐ My health information relating to the following treatment or condition:

____

☐ My health information covering the period of healthcare from (date)__________ to (date)__________

☐ Other: ______________________________

The above party may disclose this health information to the following recipient:

Name (or title) and organization ______________________________

Address ______________________________

City ____________________ State __________ Zip __________

Phone __________ Fax __________ Email __________

The purpose of this authorization is (check all that apply):

☐ At my request

☐ Other: ______________________________

☐ To authorize the using or disclosing party to communicate with me for marketing purposes when they receive payment from a third party to do so.

☐ To authorize the using or disclosing party to sell my health information. I understand that the seller will receive compensation for my health information and will stop any future sales if I revoke this authorization.

This authorization ends:

☐ On (date) ____________________

☐ When the following event occurs: ______________________________

CHARLIE Y. SONIDO, M.D., INC.

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. I may not be able to revoke this authorization if its purpose was to obtain insurance. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permissions cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be combined upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

I will receive a copy of this authorization after I have signed it. A copy of this authorization is as valid as the original.

Signature of Patient:______________________________ Date:__________

If the patient is a minor or unable to sign please complete the following:

☐ Patient is a minor:__________ years of age

☐ Patient is unable to sign because:______________________________

Signature of Authorized Represenitive:______________________________ Date:__________

Print Name of Authorized Represenitive:______________________________

Authority of representative to sign on behalf of the patient:

☐ Parent ☐ Legal Guardian ☐ Court Order ☐ Other:______________

III. Additional Consent for Certain Conditions

This medical record may contain information about **physical or sexual abuse, alcoholism, drug abuse, sexually transmitted diseases, abortion, or mental health treatment.** Separate consent must be given before this information can be released.

☐ I consent to have the above information released.

☐ I do not consent to have the above information released.

Signature of Patient or Authorized Representative:______________________________

Date:______________ Time:______________

IV. Additional Consent of HIV/AIDS

This medical record may contain information concerning **HIV testing and/or AIDS diagnosis or treatment.**

Separate consent must be given to have this information released.

☐ I consent to have the above information released.

☐ I do not consent to have the above information released.

Signature of Patient or Authorized Representative:______________________________

Date:______________ Time:______________