WAIANAE COAST COMPREHENSIVE HEALTH CENTER
www.wcchc.com

Patient Registration

PATIENT INFORMATION

Legal Last Name	First Name	M.I.	Preferred Name	Date of Birth

Legal Sex (Please check one)*
☐ Male ☐ Female

*Sex assigned at birth (Male and Female). Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence.

Gender Identity
☐ Male
☐ Female
☐ Transgender Male/Female-to-Male
☐ Transgender Female/Male-to-Female
☐ Other
☐ Chose not to disclose

Sexual Orientation
☐ Lesbian, Gay or Homosexual
☐ Straight (not lesbian or gay)
☐ Bisexual
☐ Something else
☐ Don't know
☐ Chose not to disclose

Home Address	City	State	Zip Code
Mailing Address	**City**	**State**	**Zip Code**

Please complete and indicate your preferred contact method by checking one of the boxes below:

☐ Home Phone ( ) -	☐ Cell Phone ( ) -	☐ Day Phone ( ) -	☐ E-Mail Address

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	Do You Need An Interpreter? ☐ Yes ☐ No	Primary or Preferred Language: ☐ English ☐ Other:_____

Patient Portal is WCCHC's latest technology that allows you to schedule and view appointments, request medication refills and see lab results, communicate with your health care team, ask questions about your bill and request your health record.

Are you enrolled into Patient Portal? ☐ Yes ☐ No If No, do you need assistance to enroll? ☐ Yes ☐ No

Do you have an Advance Directive?
(Form stating how much medical care you want to receive or designating someone to make medical decisions in the event you are not able to respond): ☐ Yes ☐ No

Housing Status: ☐ Not Homeless ☐ Homeless: ☐ Doubling Up ☐ Shelter ☐ Street, Beach, Etc. ☐ Transitional ☐ Unreported

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino	Farmer Status: ☐ N/A ☐ Seasonal ☐ Migrant	Active Military or Veteran: ☐ Yes ☐ No

Race (pick one below that best describes you):

☐ African American/Black	☐ Caucasian	☐ Chinese	☐ Chuukese	☐ Filipino	☐ Guamanian
☐ Japanese	☐ Korean	☐ Laotian	☐ Marshallese	☐ Micronesian	☐ Native American
☐ Native Hawaiian	☐ Portuguese	☐ Puerto Rican	☐ Samoan	☐ Tongan	☐ Vietnamese
☐ Other Asian	☐ Other Pacific Islander		☐ All Other (please specify): _____		

GUARANTOR INFORMATION

Relationship of Guarantor to Patient (Check One): ☐ Self ☐ Spouse ☐ Parent ☐ Other:_____

Legal Last Name	First Name	M.I.	Preferred Name	Date of Birth

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed	Do You Need An Interpreter? ☐ Yes ☐ No	Primary or Preferred Language: ☐ English ☐ Other:_____

Home Address	City	State	Zip Code

Please complete and indicate your preferred contact method by checking one of the boxes below:

☐ Home Phone ( ) -	☐ Cell Phone ( ) -	☐ Day Phone ( ) -	☐ E-Mail Address ( ) -

Household Size & Income Update

Patient Name: _____ MRN: _____

EMERGENCY CONTACT INFORMATION		
Emergency Contact Name:		Relationship:
Home Phone	Work Phone	Cell Phone
Emergency Contact Name:		Relationship:
Home Phone	Work Phone	Cell Phone

PATIENT EDUCATION / EMPLOYMENT			
Employer/School Name:	☐ Employed ☐ Unemployed	☐ Student	☐ Full-Time ☐ Part-Time ☐ Casual ☐ Retired
Occupation:	Family Size (includes self, spouse, & children under 18):_____	Family Income: $ _____	☐ Monthly ☐ Annual

_____ Initials

I irrevocably assign and transfer to the center all rights, benefits, and any other interests in connection with any insurance plan, health benefit plan, or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the center of all insurance and health plan benefits payable for these outpatient services. I agree that the insurer or plan's payment to the center pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid according to this assignment, to the extent permitted by state and federal law. I agree to cooperate with, and take all steps reasonably requested by, this center to perfect, confirm, or validate this assignment.

_____ Initials

I certify that the information I have furnished is true and correct to the best of my knowledge. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

_____ Initials

Patient was offered a copy of Patient Rights and Responsibilities.

_____ Initials

Patient was offered a copy of Payment Expectations.

_____ Patient's Signature

_____ Date Signed

_____ Guarantor's Signature

_____ Date Signed

Patient Registration: Insurance

Patient Name:_____ MRN: _____

PRIMARY MEDICAL INSURANCE INFORMATION

Patient's Relationship to the Insured (Check One): ☐ Self ☐ Spouse ☐ Parent ☐ Step-Child ☐ Child ☐ Other:_____				
Policy Holder Name		Date of Birth	☐ Male ☐ Female ☐ Unknown	
Plan Name	Policy # / Subscriber #	Group #	Effective Date:	Expiration Date:
Home Address		City	State	Zip Code
Home Phone	Work Phone	Cell Phone		

SECONDARY MEDICAL INSURANCE INFORMATION

Patient's Relationship to the Insured (Check One): ☐ Self ☐ Spouse ☐ Parent ☐ Step-Child ☐ Child ☐ Other:_____				
Policy Holder Name		Date of Birth	☐ Male ☐ Female ☐ Unknown	
Plan Name	Policy # / Subscriber #	Group #	Effective Date:	Expiration Date:
Home Address		City	State	Zip Code
Home Phone	Work Phone	Cell Phone		

PRIMARY DENTAL INSURANCE INFORMATION

Patient's Relationship to the Insured (Check One): ☐ Self ☐ Spouse ☐ Parent ☐ Step-Child ☐ Child ☐ Other:_____				
Policy Holder Name		Date of Birth	☐ Male ☐ Female ☐ Unknown	
Plan Name	Policy # / Subscriber #	Group #	Effective Date:	Expiration Date:
Home Address		City	State	Zip Code
Home Phone	Work Phone	Cell Phone		

SECONDARY DENTAL INSURANCE INFORMATION

Patient's Relationship to the Insured (Check One): ☐ Self ☐ Spouse ☐ Parent ☐ Step-Child ☐ Child ☐ Other:_____				
Policy Holder Name		Date of Birth	☐ Male ☐ Female ☐ Unknown	
Plan Name	Policy # / Subscriber #	Group #	Effective Date:	Expiration Date:
Home Address		City	State	Zip Code
Home Phone	Work Phone	Cell Phone		

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Consent for Treatment and Communications Form

I understand that as part of my healthcare, Waianae Coast Comprehensive Health Center (includes James and Abigail Campbell Nanakuli Clinic, Kapolei Health Care Center, Waianae Vision Care, Waiola Clinic and Waipahu Family Health Center) originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

1. A basis for planning my care and treatment
2. A means of communication among the many health professionals who contribute to my care
3. A source for applying my diagnosis and surgical information to my bill in order for WCCHC to receive payment
4. A means by which a third party payer can verify that services billed were actually provided
5. A tool for healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

By initialing I acknowledge and understand:

____ That I have been offered a copy of Notice of Privacy Practices that provides a description of information uses and disclosures.
____ That the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notices to the address I have provided.
____ That staff may acknowledge my presence in the clinic should someone call to ask for me.
____ That I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the organization ***is not required to agree to the restrictions requested.*** For requests contact the WCCHC Privacy Officer through the Compliance Department at 697-3150 or 697-3585.
____ That I may revoke this consent in writing, except when the organization has already taken action in reliance thereon.
____ That the Health Center is a teaching facility and there will be occasions when interns, residents, students or volunteers may be assisting my healthcare worker. I understand that I can decline interns, residents, student or volunteers assisting a healthcare worker by making this known (verbally or in writing) at any time to a WCCHC healthcare worker involved in my care or management.

That according to Hawaii law, I may choose to pay for services pertaining to HIV or AIDS treatment if I do not want my health information to be provided to my insurance company or anyone else without my written consent. I agree to notify this medical facility of my wishes regarding payment before these services are provided and if I fail to pay for these services, the information will be sent to my insurance company or anyone else without my written consent.

I understand that WCCHC must abide by federal and state laws, regulations or rules regarding communicable diseases by any means of spreading the disease, that even if I pay for a HIV test or AIDS treatment WCCHC will report positive test results to the Hawaii Department of Health.

I understand that I have a right to request a paper or electronic copy of my medical records and requesting an amendment to those records by following WCCHC procedures in making such requests.

____ By my initials, I request to receive fund raising materials.
____ By my initials. I request to receive marketing materials.

AUTHORIZATION FOR COMMUNICATIONS

I understand that my healthcare provider, his or her assistants or receptionists, and any workforce member may need to contact me by telephone. In the event that I am not home, by my initials I hereby expressly give my permission to leave the following information on an answering machine and/or my cellular phone, or with any other member of my household or by mail:

____ Appointment reminders or rescheduling of appointments, including OB/GYN or Behavioral Health (psychiatric) visits
____ Scheduling of an immediate follow up visit due to positive laboratory or diagnostic imaging results (results should only be given to the patient)
____ Billing and insurance inquiries

Print Patient Name: _____
Date of Birth: _____
Patient/Parent/Legal Guardian Signature: _____
Relationship if not the Patient: _____ Date: _____
Print Health Center Representative: _____
Health Center Representative Signature: _____ Date: _____

HEALTH INSURANCE PORTABILITY ACCOUNTABILITY ACT 1996 (HIPAA) CONSENT FORM ALLOWS YOUR HEALTH CARE PROVIDER TO COMMUNICATE ABOUT YOU TO YOUR FAMILY, FRIENDS OR OTHERS INVOLVED IN YOUR CARE:

By signing this form you are granting permission for your provider to communicate with the individuals listed below on any and all health information, medications, test results, recommended therapy or tests, **which the provider deems necessary** for individuals listed below to know while they are involved with your care. Your signature below is voluntary and you can withdraw consent at any time for the following listed individuals to receive your health information.

1. _____ _____ _____
   Print Name | Relationship | Contact Phone Number
2. _____ _____ _____
   Print Name | Relationship | Contact Phone Number
3. _____ _____ _____
   Print Name | Relationship | Contact Phone Number
4. _____ _____ _____
   Print Name | Relationship | Contact Phone Number

You can also designate one person with whom we may discuss your billing on your behalf. Please indicate their name here:

_____ _____ _____
Print Name | Relationship | Contact Phone Number

This consent is valid for one year from the date signed unless another date is listed here _____

_____ _____ _____
Printed Patient Name (or Guardian) | Signature (Relationship if other than patient) | Date