Patient Registration Form

Please complete entire form at time of visit

Name*_____Date_____

First Middle Initial Last

Date of Birth*____/____/____ Sex*_____ Gender_____Pronouns_____

Mobile Phone*_____Email*_____

Check if: No mobile phone ☐ No email ☐

Check to: Receive/Send mobile text notifications ☐

Receive/Send voice notifications ☐

Receive/Send email notifications ☐

Home Phone_____ Work Phone_____ Work EXT._____

Address_____

Address Apt, Suite or Floor City State Zip

Emergency Contact

Name_____Relation_____

First Last

Phone_____

Address: _____

Preferred Pharmacy :

_____

Insurance Information

Insurance Name*_____

Plan Name*_____

Insurance Address*_____

Insurance Phone*_____

Order of Benefits* Primary ☐ Secondary ☐ Tertiary ☐ Unknown/None ☐

Worker's Compensation ☐ MVA (Motor Vehicle Accident) ☐

Insurance ID*_____

Group ID _____

Effective From*_____

Relation to insured Self ☐

Child ☐ Spouse ☐ Other ☐

If MVA or Worker's Comp; Claim Number_____ Date of Accident_____

I authorize Pohala Clinic PC to bill my insurance company and receive direct payment

This assignment will remain in effect until revoked by me in writing, A photocopy of the assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not they are paid by said insurance. I hereby authorize said assignee to release all information to secure the payment.

_____ _____ **Signature**

Date

ACKNOWLEDGMENT AND CONSENT

I understand that Pohala A Place of Healing will use and disclose health information about me. I understand that my health information may include both created and received by the practice, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnosis, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that Pohala A Place of Healing may use and disclose my health information in order to:

- Make decisions about and plan for my care and treatment;
- Refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- Determine my eligibility for health plan or insurance coverage, and submit bills, claims and other related information to insurance companies or others who may be responsible to pay some or all of my health care; and
- Performa various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost-effective health care.

I also understand that I have the right to receive and review a written description of how Pohala A Place of Healing will handle health information about me. This written description is known as a Note of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of Pohala A Place of Healing and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of Pohala A Place of Healing's Notice of Privacy in effect will be posted in reception/waiting area.

I understand that I have a right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that Pohala A Place of Healing is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understand the information above and that I have received a copy of the Notice of Privacy Practices and our Financial and Insurance Policies.

_____ _____ (Patient's signature or Patient's Representative) (Date)

Description of Representative's Authority_____

WELCOME TO POHALA CLINIC PC

FINANCIAL, INSURANCE & CONTROLLED SUBSTANCES POLICIES

We hope this will answer any questions you may have about our financial and insurance policies.

Our fees are based on statistically determined standards within our community and are generally consistent with those charges in similar local practices. Our practice accepts most insurance plans. For your convenience we accept Visa, MasterCard, cash or check. There is a $25 fee for all returned checks. A $75 fee will be charged for less than 24 hour cancellation notice and for not showing up for your scheduled appointment.

PHONE CALLS SERVICES: $40- $82 Depending on time spent. Average is $55. Quick call backs and clarification of treatments are at no charge.

Only secure emails can be sent, you must sign up for Patient Fusion to send secure emails.

We ask patients to trust that Pohala A Place of Healing is honest about our time and service here. our practice offers personalized care and in order to manage our time and energy after hours and in between seeing patients in the clinic we has chosen to charge for phone/skype/email consults. The majority of medical providers require an in-clinic appointment for most of the complaints asked by phone or email. We offer phone/skype/email consults also as a convenience for patients to avoid traveling and time expense.

PRIVATE PAY/SELF-PAY: Payment in Full required. Payment is required at time of service. We offer a prompt pay discount for payment in FULL at time of service.

PRIVATE HEALTH INSURANCE: You are responsible for deductibles, co-pays, non-covered services, co-insurance and items considered not medically necessary by your insurance company. Co-pays and deductibles must be paid at the time of service and the remaining balance is due within 30 days of notice from the insurance company. Co-pays not received at time of service will be subject to a **$10 billing fee** . As a courtesy we will bill your primary insurance and will forward a copy of the charges to your secondary insurance. Patients are required to send a copy of their Explanation of Benefits (EOB) from their primary insurance carrier to their secondary insurance carrier so payment can be made.

Know your insurance coverage and requirements . Insurance coverage varies from one plan to another. Most insurance companies require the use of participation hospitals, referral physicians and laboratories when care is needed outside of your office. Please check your insurance booklet or talk to your insurance company regarding requirements of your specific plan. **It is your responsibility to inform us of the hospitals, labs and physicians your insurance company requires you to use.** We will gladly help you with any billing or insurance problems. Please bring in your insurance card for us to copy and let us know of any changes in insurance or other pertinent information as soon as possible.

After a payment and/or Explanation of Benefits (EOB) statement is received from your insurance company, a statement will be mailed as soon as possible detailing your balance when applicable. The remaining balance is due upon receipt and may be paid by check, cash, or credit card. If a balance remains outstanding with no payment arrangement for 2 months, a $20 late fee will be charged each month thereafter and if no arrangements are made, the account will eventually be sent to collections.

REQUESTS FOR LETTERS OR PROCESSING OF FORMS: Patients will be charged a $25 handling fee.

WORKER COMPENSATIONS: Yes, we accept workmans comp

MOTOR VEHICLE ACCIDENT: A $250 deposit is required from all new patients being treated for a motor vehicle accident. Patients must furnish us with the name and address of your motor vehicle coverage, date of injury and claim number prior to scheduling. Please be sure to fill out all required paperwork and submit to your insurance company, otherwise, your claim will be denied and the balance will become your responsibility. We will make every effort to file claims with the appropriate insurance carrier.

All accidents whether the fault of the patient or someone else is billed through your personal injury protection policy with your insurance company. Your insurance company will in turn go after the other insurance company to receive compensation. You will receive a statement

every month. Brace, medications, letters, forms and other charges that are patient responsibility will appear on your statement. If there is a balance due we require payment within 30 days of statement date.

Your deposit will be refunded when the insurance company pays in full, unless your Personal Injury Protection (PIP) expires, becomes exhausted, or your claim is denied. If this occurs, you may be eligible for coverage through your private health insurance. Contact them for a third party liability agreement. If this cannot be arranged monthly payments are required. Please contact the billing department if other insurance coverage is arranged or if special arrangements need to be made.

CONTROLLED SUBSTANCES POLICY: Chronic use of habit-forming drugs such as narcotics, stimulants, and benzodiazepines is seldom in the best interest of patients or prescribers. For this reason, Pohala A Place of Healing will NOT prescribe long term narcotics, stimulants, or benzodiazepines with only the rarest of exceptions. A prescribing agreement with strict parameters will be signed in the unlikely event that long term narcotics or other drugs with abuse potential are required. In addition, you will agree to periodic drug screenings. Having stipulated the above, a patient's pain or anxiety will be addressed and treated appropriately.

I have read and understand the Financial, Insurance & Controlled Substances Policies:

_____ _____

(Patient's or guardian's signature) (Date) Description of guardian's authority_____

POHALA A PLACE OF HEALING

AUTHORIZATION FOR VERBAL COMMUNICATION OF PROTECTED HEALTH INFORMATION

Regarding
:

Name_____DOB_____

Address_____

Phone_____

I permit Pohala Clinic their physicians, nurses and other personnel to discuss my health information in person or by telephone with the following family members or others directly involved in my medical care

1. Name_____

Phone number_____relationship_____

2. Name_____

Phone number_____relationship_____

Release of information under this document is limited to verbal discussions with my health care providers. This does not permit release of any written health information to the individuals named above.

This authorization will expire in one year from signature unless otherwise indicated below

___indefinite (never expires)

___ends on _____

In accordance with the conditions listed above and on the reverse side of this form, I authorize the use and/or disclosure of my medical information. This authorization includes communication of information regarding psychiatric consults and mental illness, developmental disabilities, alcohol or drug treatment, AIDS or AIDS related illness, and or HIV test results (if applicable) unless I limit the discussion to exclude the following medical
conditions:_____
_____
_____

— Patient's

signature_____Date_____

If a representative on behalf of the patient signs this release, complete the following (please see backside for instructions)

Representative's
name_____

Relationship to patient_____