Pali Women's HEALTH CENTER Pali MEDISPA

PATIENT INFORMATION

Name:_____ Marital Status:_____ Date of Birth:_____

Race:_____Ethnicity:_____Language Spoken:_____

Address:_____

City:_____State:_____ Zip Code:_____ S.S#:_____

Mailing Address (if different):_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____Cell Phone:_____Work Phone:_____

Referred By:_____

Employer:_____ Occupation:_____

Work Address:_____

Spouse's Employer:_____ Phone Number:_____

Primary Insurance:_____

Address:_____

ID#:_____ Group #:_____

Policy Holder's Name:_____Date of Birth:_____ Relationship_____

Secondary Insurance:_____

Address:_____

I.D.#:_____ Group #:_____

Policy Holder's Name:_____Date of Birth:_____ Relationship_____

PERSON TO CONTACT IN CASE OF AN EMERGENCY:

Name:_____ Phone #:_____

Address:_____

Relationship to Patient:_____

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I also authorize payment from my insurance company to be made directly to PALI WOMEN'S HEALTH CENTER.

I hereby agree that if payment on my account is not made in full when due, I agree to be responsible for all collection costs including attorney's fees. **Except for collection actions against me, I agree that any controversy or claim arising out of or relation to the Physician/Patient relationship herein, or the breach thereof, shall be settled by Arbitration in accordance with Commercial Arbitration Rules of the American Arbitration Association and judgment thereof. I understand that by agreeing to Arbitration, I am waiving my rights to a jury trail.**

Signature:_____Date:_____

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MEANINGFUL USE MEASURE

Patient Name:_____ Date:_____

In compliance with Meaningful Use Measure 170304(f), patients will be able to have access to their Personal Health Records via the internet.

If you would like to access your Personal Health Record via the internet, and receive reminder emails for annuals, we will need to obtain your email address.

Annual reminder letters will only be sent out via email. Also, all lab results and all imaging will only be availed on your patient portal.

Email Address:_____

If you wish to decline internet access to your health record, please print "Decline" on the line above.

Are interested in any Cosmetic Procedures? ☐ YES

Would you like to receive emails regarding our Pali MediSpa procedures, events and promotions? ☐ YES

How were you referred to this office?

Physician:	Friend:	Website:	Facebook:	Yelp:	Internet:	Former Patient:	Other:
_____	_____	_____	_____	_____	_____	_____	_____

SIGNATURE:_____

Pali Women's HEALTH CENTER
Pali MEDISPA

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With this consent, the doctors and staff may use and disclose protected health information (PHI), about me to carry out treatment, payment, and healthcare operations (TPO)

With this consent, the doctor and staff may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With this consent , the doctor and staff may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, the doctor and staff may speak and release my PHI to the following spouse, family member, relative, friend or parties listed below: (if you do not want your Health Information shared with anyone please leave blank)

	Name	Relationship
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

I understand that if my PHI is disclosed to a party who is not required to comply with the federal privacy protection policies, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule.
This consent covers the period of time from my first visit until I revoke my consent in writing. I release the doctor and staff from all legal responsibility that may arise from this authorization.

By signing this form, I am consenting to the doctor and staff's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

_____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient Print name of Legal Guardian

I have read the notice of the uses and disclosures of Protected Health Information. I was informed that I might also obtain a printed copy of the notice from the receptionist. I hereby acknowledge that I have viewed a copy of the notice.

_____ _____

Signature Date

Pali Women's HEALTH CENTER Pali MEDISPA

PATIENT FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Pali Women's Health Center, Inc. as your healthcare provider. We are honored by your choice and committed to providing you with the highest quality healthcare. We ask that you read and sign this form to acknowledge your understanding of our patient financial policies, which are as follows:

- The patient is ultimately responsible for the payment of his/her treatment and care
- The patient is responsible for charges associated with Insurance co-pays or non covered charges.
- The patient is responsible for any costs associated with collections of patients balance
- Patient statements are mailed monthly. The patient is responsible for making a payment, or for arranging a payment plan, within 30 days of the date that appears on his/her patient statement.
- The patient is responsible for providing their correct insurance at time of service
- The patient is aware that failure to pay for his/her treatment and care will result in collection actions being taken to collect the debt (i.e. being sent to a collection agency)
- Patient Authorizations

By my signature below, I hereby authorize assignment of financial benefits directly to Pali Women's Health Center, Inc. and associated healthcare entities for services rendered as allowable under standard third party contracts.

I understand that I am financially responsible for charges not covered by this assignment.

I have read, understand, and agree to the provisions of this Patient Financial Responsibility Form:

Signature of Patient or Guardian:_____Date:_____

Waiver of Patient Authorizations

I DO NOT wish to have information released and prefer to pay at the time of service and/or to be responsible of charges and to submit claims to my insurance company at my discretion

Signature of Patient or Guardian:_____ Date:_____

HIPAA Notice of Privacy Practices

With my consent, **Pali Women's Health Center** may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to **Pali Women's Health Center** Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Pali Women's Health Center** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Pali Women's Health Center** Privacy Officer at 642 Ulukahiki Street, Suit 305 Kailua, HI 96734.

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our website.

By signing this form, I am consenting to **Pali Women's Health Center** use and disclosure of my PHI to carry out TPO. If I do not sign this consent **Pali Women's Health Center** may decline to provide treatment to me.

My signature below indicated that I have been provided with a copy of the Notice of Privacy Practices.

_____ _____

Signature of Patient or Legal representative Date

If signed by Legal Representative, relationship to patient:_____

_____ _____

Signature of staff giving Notice of Privacy Practices Date

(with/without client signature/acknowledgement)

Pali Women's HEALTH CENTER Pali MEDISPA

Todays Date:_____

PATIENT MEDICAL HISTORY FORM

Patient Name:_____ Primary Care Physician:_____

Reason For Today's Visit:_____

Current List of Medications:_____

_____

List any health conditions (ex: Diabetes, high blood pressure):_____

_____

Allergies to medications/x-ray dye/latex etc.:_____

Last Menstrual Period:_____ Are your periods Light, Normal, or Heavy?(please circle)

How often are your periods? Every 28 days, Every 20-25 days. Every 35-40 days, or Irregular? (please circle)

How long do your periods last? 1-3 days, 3-5 days, 5-7 days, or more than 7 days? (please circle)

Do you have cramping with your periods? No or Yes. If yes: Mild, Moderate, Severe? (please circle)

Are you currently sexually active: Yes or No (please circle) Birth Control Method:_____

Last pap smear:_____ Do you have a history of abnormal pap smears? Yes or No

Last Mammogram:_____ Last Bone Density:_____ Last Colonoscopy:_____

Pregnancy History:

	Year	Male/Female	Weight	Vaginal/C-section	Complications
1.					
2.					
3.					
4.					

Surgical History:

	Date	Type Of Surgery	Doctor	Hospital
1.				
2.				
3.				

Hospitalization (other than for surgery or child birth):_____

Family History:

Any relevant family history(ex: cancer, diabetes, hypertension? If so, who and what kind:_____

_____

Social History:

Do you smoke cigarettes? If yes, how much per day?_____

Do you drink alcohol? If yes how many drinks per week?_____

Any recreational drug use? Yes or No (please circle)

Do you exercise? If so how many times per week:_____

Marital Status:_____ Occupation:_____