MOLOKAI OHANA HEALTH CARE, INC. ~ MOLOKAI COMMUNITY HEALTH CENTER

Today's Date:_____

NAME: _____**Date of Birth**:_____ **Gender** (Circle One): M☐ F☐
Last First MI

ADDRESS: _____ **Social Security No.** _____
Mailing Address City, State Zip Code

PHONE NUMBER(s): Home: _____ Cell: _____ Other: _____**EMAIL**:_____
☐ OK to leave message with detailed information ☐ Leave message with call-back number only

MARITAL STATUS (Circle One): Child☐ Single☐ Married☐ Divorced☐ Widow☐

EMPLOYER/EMPLOYED BY: _____ Work Ph:_____

SPOUSES NAME: _____ Phone: _____

US CITIZENSHIP: ☐ US Citizen by Birth ☐ Naturalized Citizen ☐ US Citizen 1st Generation ☐ Immigrant ☐ Refugee
☐ Permanent Resident/Alien ☐ Student Visa ☐ Other _____

MILITARY STATUS: Have you ever been active in the Uniformed Services ☐ Yes ☐ No
AGRICULTURE STATUS: ☐ Non-Agriculture ☐ Seasonal ☐ Migrant ☐ Employed year round ☐ Retired Farm worker

ETHNICITY/ORIGIN:
☐African Am ☐Asian ☐Caucasian ☐Native Hawaiian
☐Other Pacific Islander ☐Native Alaskan /American Indian
☐Other_____ ☐More than one race ☐Refuse to Report

☐Hispanic ☐Non Hispanic

Monthly Family Income:
Before Deductions: $ _____
Family size: _____

If patient is a minor, please print name of parent or legal guardian and address if different from patient.

Father's Name: _____ Mother's Name: _____

RESPONISBLE PARTY (Guarantor): ☐ **Same as Patient**

Name:_____ Phone:_____

Address:_____

INSURANCE INFO:

☐ **Same as Patient** ☐ **Same as Guarantor** **Relationship to Insured/Guarantor:**_____

_____ _____ _____ _____ _____
Primary Insurance Group Plan/No. Member ID No. Effective Date Subscriber Name

_____ _____ _____ _____
Subscriber Address Subscriber Phone Subscriber SSN Subscriber DOB

☐ **Same as Patient** ☐ **Same as Guarantor** **Relationship to Insured/Guarantor:**_____

_____ _____ _____ _____ _____
Secondary Insurance Group Plan/No. Member ID No. Effective Date Subscriber Name

_____ _____ _____ _____
Subscriber Address Subscriber Phone Subscriber SSN Subscriber DOB

PATIENT NAME:_____

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Address:_____ Phone: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

You may review our **"Notice of Privacy Practice" (Notice)** for additional information about the uses and disclosures of information described in the CONSENT prior to signing this CONSENT. One copy of the **Notice** is displayed in our waiting room and a single copy will be provided to you if you choose to have a copy. Please verify here that you have been offered a copy of our **Notice** or have looked at the display copy in the waiting room with your initials here: _____.

Because we reserved the right to change our privacy practices in accordance with the law, the terms contained in the **Notice** may change. We will post a copy of the **Notice** in our waiting room and the **Notice** will have in the upper right hand corner of the first page, the effective date of the **Notice.** We will also provide you with a copy of the **Notice** upon request.

As more fully explained in the **Notice**, you have the right to request restrictions on how we use and disclose your protected health information for treatment, payment, and health care operations purposes. **We are not required to agree to your request if your protected health information is necessary to provide you with emergency treatment.**

You have the right to revoke this CONSENT provided that you do so in *writing,* except to the extent that we have already used or disclosed the information in reliance on the CONSENT

MCHC will charge a processing fee of $0.50 per page if request for personal medical records is over 10 pages.

I consent **Molokai Community Health Center** to use and disclose the health and medical information for _____(name of patient) the following purposes (check all that apply):

- ☐ **Treatment** (Includes activities performed by a health care provider directly delivering care to you, coordinating or managing care provided to you with third parties, and consultations with and between physicians and other health care providers)
- ☐ **Payment** (Includes activities involved in determining your eligibility for health plan coverage, billing and receiving payment for your health benefit claims, and utilization management activities including review of health care services for medical necessity, justification of charges, precertification and preauthorization of services)
- ☐ **Health Care Operations (**Includes the necessary administrative and business functions of your health care provider.)
- ☐ **Other** (Explain): Consent to obtain medication history from pharmacies, other health providers and/or my health insurance.

_____ _____

Patient Signature (Self) Date

_____ _____

Signature of Person Authorized by Law (Parent/Legal Guardian if under 18 years old) Date
Must present written proof of guardianship, custody or POA.