SLEEP CENTER HAWAII

Aiea
99-128 Aiea Heights Dr #101
Aiea, HI 96701

Kailua Kona
75-167 Kalani St #205
Kailua Kona, HI 96740

Hilo
56 Kamehameha Ave
Hilo, HI 96720

PATIENT REGISTRATION

PATIENT INFORMATION

Last Name: _____

First Name: _____

Middle Name: _____

Date of Birth: _____ Age: _____

__ Single __ Married __Widowed __ Separated

__ Divorced

Sex: Female ____ Male ___ Transgender _____

Full Social Security Number: _____

Address: _____

City: _____State_____ Zip_____

Best Contact Phone Number: _____

Alternate Phone: _____

Spouse: _____

Emergency Contact: _____

Emergency Phone: _____

EMPLOYMENT INFORMATION

__ Full time __ Part time __ Retired __ Self Employed

Occupation: _____

Employer: _____

Employer Address: _____

Employer Phone Number: _____

REFERRAL INFORMATION

Referring Physician: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone Number: _____

PRIMARY INSURANCE

Subscriber Name: _____

Subscriber Date of Birth: _____

Subscriber/Member ID: _____

Group #: _____

Effective Date: _____

SECONDARY INSURANCE

Subscriber Name: _____

Subscriber Date of Birth: _____

Subscriber/Member ID: _____

Group #: _____

RESPONSIBLE PARTY

Relationship to Patient: _____

Last Name: _____

First Name: _____

Address: _____

City: _____State_____ Zip_____

Phone number: _____

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HIPAA PRIVACY NOTICE

With this consent, the doctor and his/her 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 his/her staff may call me (number designated below) and leave a message on voicemail 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.

Voicemail Phone Number: _____

With this consent, the doctor and his/her staff may speak and release my PHI to the following spouse, family member, relative, friend or parties listed below.

Name Relationship Name Relationship

_____/ _____ _____/ _____

With this consent, the doctor and his/her staff may text or email me appointment reminders.

Text appointment reminders: YES / NO **Email appointment reminders:** YES / NO

Designated Cell Phone: _____

Designated Email Address: _____

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

Designated Mailing Address: _____

_____, Hawaii _____

This consent covers the period of time from my 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 his/her staff to use and disclose of my PHI, but only 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. I have read the Notice of the Uses and Disclosures of Protected Health Information and may obtain a printed copy of the notice from the receptionist.

_____

Signature of Patient or Legal Guardian Date

_____

Print Name of Patient

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Financial Policy

Thank you for choosing Sleep Center Hawaii and welcome!

We are dedicated to providing the best possible care to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

Depending on your insurance, a copay/co-insurance will be collected at the time of service. For your convenience, we accept cash, check, and all major credit cards.

Your insurance is an agreement between you and your insurance company. As a courtesy to you, we will file your insurance claims for you if you assign benefits to the physicians. If your insurance company does not pay within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any over payment to you.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. We highly recommend that you read your insurance booklet or copy of the contract your policy falls under, or call your insurance representative to determine your benefits.

In some instances, you may be contacted by your insurance company to provide any additional information they may request regarding you treatment, preexisting conditions, accidents or other insurance coverage. Please respond to their requests in a timely manner to avoid denial of your claims.

Be prepared to present your insurance card and proof of identity (e.g. driver's license) at each visit. You will be responsible for providing a change of address, telephone number and/or insurance information anytime a change occurs.

A prepayment of your deductible and coinsurance will be required for you portions of our fees, based on your contract allowable. Any balance remaining, after your health plan pays, is your responsibility. Payment is due upon receipt of a statement from our office.

We will look to the adult accompanying a minor for payment of all services rendered to minor patients.

I understand and agree that any unpaid charges shall be paid promptly by me in accordance with terms of this agreement.

Our Durable Medical Equipment (DME) division that dispenses CPAP/BIPAP machines and accessories may ask to keep a credit card on file before dispensing the equipment.

If you have any questions, please feel free to discuss them with one of our patient billing representatives at (808) 485-1122.

Patient Signature: _____ Date: _____

Witness: _____ Date: _____

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