HAWAII PACIFIC NEUROSCIENCE

Thank you for choosing our office! In order to serve you properly, we will need the following information.
Please print clearly. All information will be confidential.
FIELDS MARKED * REQUIRED FOR PRESCRIPTION AND BILLING PURPOSES

Patient Information

Name* _____ ☐ Male ☐ Female Birthdate* ____/____/_____
LAST FIRST MI

Mailing Address* _____ City_____ State _____ Zip code _____

Street Address* _____ City_____ State _____ Zip code _____

Primary Phone* (_____)_____-_____ Preferred method of contact*: ☐ Call ☐ Text ☐ No Preference

Alternate Phone (_____)_____-_____ SSN* _____

Email Address _____ Preferred Pharmacy* _____

Primary Physician* _____ Referring Physician _____

Marital Status: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Patient's Employer _____ Work Phone (_____)_____-_____

Business Address _____ City_____ State _____ Zip code _____

Emergency Contact _____ Relationship _____ Phone (_____)_____-_____

Approved Contact _____ Relationship _____ Phone (_____) _____-_____

*By approving this contact, you are allowing this person access to all your PHI information.

Power of Attorney?* ☐ Yes ☐ No If yes, who? _____ **Please provide a copy of the POA, if applicable**

Responsible Party

Name of Responsible Party* _____ Relationship to patient* _____

Birthdate _____/_____/_____ Email Address _____

Mailing Address _____ City_____ State _____ Zip code _____

Primary Phone* (_____)_____-_____ Alternate Phone (_____)_____-_____ SSN _____

Responsible Party's Employer _____ Work Phone (_____)_____-_____

Primary Insurance

Insurance Company* _____ Subscriber ID*_____ Group No. _____

Name of Insured*_____ Relationship to patient* _____
LAST FIRST MI

Insured's Birthdate* _____/_____/_____ Email Address _____

Mailing Address _____ City_____ State _____ Zip code _____

Street Address _____ City_____ State _____ Zip code _____

Primary Phone* (____)_____-_____ Alternate Phone (____)_____-_____ SSN* _____

Do you have additional insurance? ☐ Yes ☐ No If yes, complete the following:

Secondary Insurance

Insurance Company* _____ Subscriber ID* _____ Group No. _____

Name of Insured* _____ Relationship to patient* _____
LAST FIRST MI

Insured's Birthdate* _____/_____/_____ Email Address _____

Mailing Address _____ City_____ State _____ Zip code _____

Street Address _____ City_____ State _____ Zip code _____

Primary Phone* (____)_____-_____ Alternate Phone (____)_____-_____ SSN* _____

Race (check one of the following) :

- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian
- ☐ African American
- ☐ Asian
- ☐ Caucasian
- ☐ Hispanic
- ☐ Other Pacific Islander
- ☐ Other Race
- ☐ Prefer not to say

Ethnicity (check one of the following):

- ☐ Hispanic or Latin
- ☐ Not Hispanic or Latin
- ☐ Prefer not to say

Language (check one of the following):

- ☐ English
- ☐ Other: _____

Translator needed? ☐ Yes ☐ No

I certify that the information provided is true and correct to the best of my knowledge and belief and I understand and agree that I have a continuing obligation to advise Hawaii Pacific Neuroscience, LLC if there is a change in circumstances.

Patient or Guarantor (Print Name)	Patient or Guarantor Signature	Date

Consent to Release of Medical Information

Patient's Name:_____ DOB: _____

I authorize Hawaii Pacific Neuroscience to disclose/request my health information including copies of records as necessary to/from:

1. Any health insurance plan or company of billing service that provides insurance coverage for me for the purpose of payment of charges, as well as any workers' compensation, no fault or administrative proceeding for the purpose of evaluating my medical condition.
2. Any insurance company that provides liability insurance coverage for Hawaii Pacific Neuroscience to evaluate clinical performance.
3. Consulting and treating physicians, diagnostic facilities, labs, radiology/imaging, outpatient facilities and hospitals and other health providers for the purpose of continuity of care.
4. External sources (i.e. pharmacies), granting permission to the doctors and medical assistants view your prescription history.
5. Other organizations, permitting the release of medical data in order to adjudicate claims associated with the patient.

All medical information with no exceptions will be disclosed / requested as necessary to/from the above. I authorize faxing of information as necessary. This authorization shall cover the period of time from my first visit to my last visit and will end 2 years after the date of my last visit. I permit a copy of this authorization to be used in place of the original.

_____ _____ _____

Patient or Guarantor (Print Name) Patient or Guarantor Signature Date

Patient Financial Responsibility Agreement

****Please note that this agreement states your financial responsibility as a patient of Hawaii Pacific Neuroscience, LLC, and addresses the possibility of incurring out of pocket expenses.**

Patient Name: _____ DOB: _____

Insurance Claims/Payment*: *As a courtesy, Hawaii Pacific Neuroscience, LLC will file your insurance claims for you; however, in the event that your insurance company denies payment for any reason or has not paid within 60 days, you and/or guarantor will be responsible for any balance due. It is also you and/or guarantor's responsibility to provide current insurance information, including the insurance subscriber number and mailing address, and to follow up on any benefit questions with the insurance carrier. We must emphasize that we are a medical care provider; our relationship is with the patient and not the insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

Referral: In the event that your insurance requires you to receive a referral by your primary care physician prior to being seen by our practice, it is ultimately your responsibility to obtain one. The balance for a claim that a referral was required but not obtained will be your responsibility.

***Patient Account Charges and Statements*:** Co-Payment and/or any balance due on your account are requested at the time of your scheduled visit; we accept cash, check, and credit card. If you have no insurance plan at the time of your visit you will be required to put down a $150 down payment before being seen by our practice. Additional charges may be incurred and will be the patient or guarantor's responsibility. You may contact our billing personnel to arrange and sign a monthly payment plan agreement if necessary. Hawaii Pacific Neuroscience, LLC may impose a collection fee and interest charge on any unpaid balance.

***Collections*:** If your account is over 90 days old with no payment activity, your account will be transferred to a collection agency. If applicable, you and/or guarantor is responsible for all related expenses incurred in the collection of the delinquent amount due. These may include, but are not limited to attorney's fees and/or other costs that Hawaii Pacific Neuroscience, LLC considers necessary in order to collect the delinquent amount due. To avoid collections, please be sure to pay your co-pay/balance at the time of your visit or mail in your payments by the due date shown on your statement.

***Returned Checks*:** All returned checks will be subject to a $25.00 NSF fee and any bank fees incurred. **In addition** to the returned check, **and** the NSF fee & bank fees, you will also be required to pay any outstanding balance by your next scheduled visit. As a result, you may be placed on a cash/credit card only payment method for future appointments.

No Show and Cancellation Charges*:** As a courtesy to our physicians, staff, and other patients, we ask that you cancel your appointments at least 24 hours in advance. ***There is a $75.00 fee for not showing up for or cancelling your visits with less than 24 hours notice. If cancelling, rescheduling or not showing for appointments becomes a habit, we reserve the right to transfer care back to your primary care physician.

By signing below, you are agreeing to and understand the above financial agreement and that you understand, as the patient or guarantor, that you are responsible for any charges incurred and agree to pay them as required within 30 days of receiving your billing statement.

_____	_____	_____
Patient or Guarantor (Print Name)	Patient or Guarantor Signature	Date