Hawaii Cancer Care

QMC POB II (808) 524-6115
Liliha Clinic (808) 536-4885
Mary Savio Building
QMC West Oahu (808) 536-4888
Castle Medical Center (808) 524-6115

Today's Date:_____

PATIENT REGISTRATION

PLEASE PRINT AND COMPLETE ALL ENTRIES

PATIENT NAME (LAST -- FIRST -- MIDDLE INITIAL)	MAILING ADDRESS		
CITY, STATE	ZIP	HOME PHONE	CELL PHONE
DATE OF BIRTH	SOCIAL SECURITY NUMBER	SEX ❑ Male ❑ Female	MARITAL STATUS ❑ Single ❑ Married ❑ Other_____
E-MAIL ADDRESS	PATIENT EMPLOYER & ADDRESS (CITY – STATE – ZIP CODE)	EMPLOYER PHONE	
PREFERRED LANGUAGE	ETHNICITY AND RELIGION (OPTIONAL)		

INSURED/RESPONSIBLE PARTY INFORMATION RELATION TO PATIENT: ❑spouse ❑parent ❑guardian

NAME (FIRST -- LAST -- MIDDLE INITIAL)	ADDRESS (if different from patient)			
HOME PHONE	WORK PHONE	SSN	BIRTH DATE	EMPLOYER

INSURANCE INFORMATION

PRIMARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE	
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE
SECONDARY INSURANCE NAME	ADDRESS (STREET - CITY - STATE - ZIP)	PHONE	
GROUP NUMBER	ID NUMBER	EMPLOYER	EMPLOYER PHONE

PRIMARY DOCTOR/FAMILY DOCTOR	REFFERING DOCTOR	
IN CASE OF EMERGENCY CONTACT *(PLEASE INCLUDE AT LEAST 2 CONTACTS)*	RELATIONSHIP	PHONE NUMBER
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

ASSIGNMENT AND RELEASE : I hereby authorize my insurance benefits be paid directly to the physician and I am financially responsible for non-covered services. I also authorize the physician to release any information required in the processing of this claim and all future claims. If my account is sent to a collection agency, I agree to pay all collection and attorney fees.

SIGNATURE (Patient or, if minor Signature of parent or guardian)	DATE

RELEASE OF INFORMATION

I understand that:

- once "this facility" discloses my health information by my request, it cannot guarantee that Recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state laws governing the use and disclosure of my health information.
- I may make a request in writing at any time to inspect and/or obtain a copy of my health information maintained at this facility as provided in the Federal Privacy Rule 45 CFR (164.524).
- my records are protected and cannot be disclosed without written permission
- this Authorization will remain in effect for one year or I provide a written notice of revocation to the Medical Record Department.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE	DATE
IF SIGNED BY LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT	SIGNATURE OF WITNESS (Optional):

Hawaii Cancer Care

Financial Agreement & Responsibility

The services that will be provided to you will be paid (check one of the following):

SELF-PAY PLAN

Definition: Under this payment method, charges for services are paid in full prior to the day of the treatment.

INSURANCE PLAN

Definition: Charges will be billed to your insurance company. Deductible and Co-payment if applicable is due on the day of your treatment.

1. I understand that it is my responsibility to provide Hawaii Cancer Care with a copy of my current insurance card and to obtain a referral from my Primary Care Physician (if required by my insurance). Hawaii Cancer Care is not obligated to see patients without a valid referral. If I do not have insurance or my insurance does not cover my treatment, I will be considered Self-Pay patient and be financially responsible for the total amount of the services provided. I will notify Hawaii Cancer Care upon any change in my insurance.
    a. I further understand that in consideration of the services provided, I am directly and primarily responsible to pay the amount of all charges incurred for services and procedures rendered at Hawaii Cancer Care which are not covered or reimbursed by my insurance. I am responsible for any applicable deductible or co-payments prior to the provision of services. Hawaii Cancer Care will provide me with an estimate of my total financial responsibility and the date by which this amount must be paid in full. I understand that due to the individual needs of each treatment, or procedure, this fee is only an estimate. In the event my care exceeds the amount of the estimate, I will be financially responsible for the balance.
2. My right to payment for all pharmaceuticals, procedures, tests, medical equipment rentals, supplies and nursing/physician services including major medical benefits is hereby assigned to Hawaii Cancer Care This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services.

THIS AGREEMENT WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING.

I have read and accept the terms and conditions of the Financial Agreement & Responsibility.

Printed Name of Patient: _____ **Date:** _____

Patient Signature/Representative: _____ **Date:** _____

I have read and received a copy of the above statements and accept the terms. A duplicate of the statement is considered the same as original.

Created 12/5/10: ryh, Revised 3/2/11: ryh, Updated 10/4/16: jm

HAWAII CANCER CARE, INC.
PROVIDER REQUEST FOR HEALTH INFORMATION

INSTRUCTIONS: PLEASE FILL IN ALL RELEVANT ITEMS ASTERISKED (*)

*Date: _____

*Name of requesting physician: _____

*Address: _____

*Contact Name: _____ Ph #: _____ Fax #: _____

***I am requesting protected health information from: _____**

***Regarding the following patient:**

Patient Name: _____ Birth Date: _____ SS#: _____

Other names patient may be known by: _____

***Purpose of Request:**

☐ Treatment: Patient has an appointment on ____/____/____ at _____ ☐ Payment/Billing

***Records being requested for the following dates of service: _____** to _____

***Specific Information Requested:**

☐ Billing Information ☐ Progress Notes ☐ History and Physical Exam
☐ Discharge Summary ☐ Clinic Visit Notes ☐ ER/Hospital Records
☐ Laboratory Test Results ☐ Pathology Reports ☐ Surgery Reports
☐ Radiology Results ☐ Photos, videotapes, digital or other items

☐ Other (please specify) _____

_____ (initial) I agree to the release of the following information should it be contained in my medical record: Acquired Immune Deficiency Syndrome (AIDS) of HIV, Alcohol and/or drug abuse treatment, or behavioral or mental health services. (If I do not specifically agree, this information will not be disclosed):

***Unless otherwise revoked, this authorization will expire on the following date or event: _____.**
If a date or event is not specified, this authorization will expire two (2) years from my date of signature below.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the requesting physician. I understand that the revocation will not apply to information that has already been disclosed in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not to sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclose and the information may not be protected by federal confidentiality rules. I hereby release the physicians of Hawaii Cancer Care, INC., its employees and its agents from all liability and all claims of any nature pertaining to the disclosure of information described above.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Relationship or Personal Representative Signature of Witness