Hawaii Cancer Care

☐ **WATERFRONT PLAZA**
500 Ala Moana Blvd, Suite #6-230
Honolulu, HI 96813
Telephone: (808) 524-6115
Fax: (808) 539-1711

▪ **Westridge Aiea**
98-150 Kaonohi Street, Unit B-219
Aiea, Hawaii 96701
Telephone: (808) 539-2272
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PATIENT REGISTRATIION

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 all or partial 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.