DOCTORS ON CALL MAUI

Today's Date: _____

Patient Name (last, first): _____ DOB: _____

Reason for Visit: _____

_____

Medications & DOSES you take daily or only as you need it: _____

_____

Allergies to Medications: _____

[ ] CHECK HERE if you have been seen in the last 4 weeks. STOP NOW & ONLY WRITE NEW OR UPDATED information below:

Medical Issues (such as diabetes): _____

Surgeries: _____

CIRCLE symptoms you are experiencing related to your visit TODAY. Anything not circled will be considered "NO":

Systemic Symptoms: | fever | chills | body aches | fatigue | feeling weak | acting fussy, not like self | sweating excessively|
| lymph nodes tender or swollen | abnormal weight loss |
Head Symptoms: | sinus pain | tooth pain | headache | head injury |
Eye symptoms: | eye pain | red eyes | swollen eyelid | itchy eyes | eye discharge | feels like something in eye | eye injury |
|blurry vision | loss of vision|
ENT Symptoms: | earache | ear pressure | ears feel plugged | hearing loss | ringing in ears | drainage from ears |
| sore throat | nasal discharge | nasal stuffiness | hoarseness | sneezing |
Cardiovascular Symptoms: | chest pain | chest tightness | fluttering heartbeat | fast heart rate |
| generalized swelling (feet/legs, hands/fingers, or face) |
Pulmonary Symptoms: | dry cough | coughing up phlegm | coughing up blood | difficulty breathing | shortness of breath | wheezing |
GI symptoms: | nausea | vomiting | loss of appetite | abdominal pain | abdominal cramps | bloating |diarrhea | constipation |
GU Symptoms: |painful urination | urinary urgency | urinary frequency | blood in the urine | urine odor | bladder spasms |
| unable to urinate | urinary loss of control |
Musculoskeletal Symptoms: | neck pain | rib pain | upper back pain | mid-back pain | lower back pain | buttock pain | hip pain |
| leg pain | knee pain | ankle pain | foot pain | toe pain | shoulder pain | arm pain | elbow pain | hand pain | finger/thumb pain |
| joint pain | joint swelling | muscle aches | muscle cramps | muscle weakness |
Neurological Symptoms: | numbness | tingling | dizziness | fainting | migraine headache|
Psychological Symptoms: | sleeplessness | depression | anxiety | ADD | ADHD |
Skin Symptoms: | rash | hives | itching | burning pain| blister | open sore | skin pain | skin redness | skin patch with swelling |
| pus drainage | bleeding | bruising | abrasion (scratch) | cut (laceration) | skin lump (tag/mole/wart) | sunburn | burn |
Bite or Sting: by what? _____
Other: | fall | injury or accident |
ANY OTHER SYMPTOMS (please list here): _____

(FOR STAFF USE ONLY (REV 3/31/15)
LOCAL STAYING AT _____ PHARM _____ LAST TETANUS _____
T _____ P _____ BP _____ O2 _____ LMP _____ WT _____ HT _____

Policy #:_____ Group #: _____Relationship:_____

I hereby authorize the payment of medical benefits to Ka'anapali Medical Services, dba Doctors On Call for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.

I further agree to pay all collections costs, attorney fees, and other collection costs that may be incurred to enforce the collection of any amounts outstanding.

I hereby authorize Doctors On Call to release any medical information necessary to complete and process my insurance claims.

I authorize Doctors On Call to treat me and use my personal information for health care operations.

I have been advised of and/ or offered a copy of HIPAA privacy guidelines.
Patient OR Insured's Signature (If a Minor, Responsible Party Signature):

_____
Date_____

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This office is required by federal regulation, known as the HIPAA, **The Health Insurance Portability and Accountability Act of 1996,** to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices. This office will not disclose your health information except as described in this Notice. The office is permitted by federal privacy laws to make uses and disclosures of your health information for purposes of treatment, payment and health care operations. Protected health information is the information we create and obtain in providing our services to you. The health information about you is documented in a medical record and on a computer. Such information may include documenting your symptoms, medical history, examination and test results, diagnoses, treatment, and applying for future care of treatment. It also includes billing documents for those services.

OUR COMMITMENT TO YOUR PRIVACY:

This office is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realized that these laws are complicated, but we must provide you with the information.

WHO HAS ACCESS TO THIS INFORMATION?

Any person or persons who designate in writing, people directly involved in your medical care, people creating and maintaining your medical record, and those entities that need your information to process health care claims and obtain payment for my services has access to your Protected Health Information. Entities such as Governmental Oversight agencies, Judicial and Administrative Proceeding, Law Enforcement Agencies, Coroners and Medical Examiners, and Organ Procurement Organizations may obtain copies of your Protected Health Information. These entities are mandated by Law and this practice has no jurisdiction over such entities.

HOW WE PROTECT YOUR INFORMATION:

We release your information on to those who need your information. We maintain physical, electronic, and procedural safeguards so that no one but persons involved in your healthcare or entities that need this information for claims processing have access to your Protected Health Information.

YOUR RIGHTS:

You have the right to inspect your Protected Health Information. You also have the right to amend any errors you may find in your records.

DISCLOSURE AND CONSENT:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Please name person(s) we may contact and/or discuss your medical or billing information: (If no one or self, please leave blank. Parents of minors 0-18 please leave blank.

Name:_____

Relationship:_____

DOB: _____Phone Number:_____

I hereby understand and accept the above criteria:

Patient / Other Responsible Person

Signature:_____

Printed Name: _____Date: _____

The following sets forth the general billing policy of Kaanapali Medical Services, dba Doctors On Call. Please review this information and sign where indicated.

☐ I understand that it is my responsibility to provide to Doctors On Call the accurate billing information at the time of check-in and to notify this office of any changes to this information.

☐I understand that it is my responsibility to know my urgent care co-pay (which can be different than my Primary Care co-payment)and to pay prior to services bring rendered. I understand that this is a contractual agreement that I have with my health plan and that the clinic also has a contractual agreement with my health plan to collect co-pays at the time of service, and they are required to report to the carrier any enrollees failing to pay the co-pay.

☐I understand that if I present an insufficient funds check (NSF check) for payment on my account that I will be charged a
$25 NSF fee. I further understand that to rectify my account, I will be required to pay with cash, a money order, cashier's check, or credit card.

☐I understand that prior authorization is not guarantee of payment, and that I am responsible for any bills not paid by my insurance carrier additionally I understand that the clinic may take a verbal request to use my credit card for payment on my account.

☐I understand that Doctors on Call will verify my insurance eligibility, deductible amounts, and coinsurance amounts prior/during my visit and collect the deductible and/or coinsurance/copays at that time. I further understand that THE FEE I AM QUOTED IS AN ESTIMATE based on: 1) anticipated procedures to be performed and 2) current information provided to clinic by my insurance carrier.

☐I understand that I will be billed for any amounts due by me (co-payments/coinsurance amounts/ deductibles) and I have a financial responsibility to pay these amounts. I understand that Doctors On Call will not carry a balance past 90 days. I further understand that if I have not made payment prior to second statement being mailed, that the third statement will be marked as "Final Notice" and may be sent to an outside collection service if I do not fulfill my financial obligations. I also understand that I will be responsible for any collection, interest, or legal expenses associated with the collection efforts.

☐ I understand that certain Medical Services, Supplies and Medications are not covered or reimbursable by my insurance carrier. I elect to have these proposed services performed at my expense. I agree to pay the full amount of these charges an an out of pocket expense. I also understand and agree that Kaanapali Medical Services, dba, Doctors on Call, may bill and collect charges for purposed services.

The following are some of the services that may not be covered by my insurance:

- ***Certain procedures including audiograms and ear irrigations***
- ***Administered Injectable Medications***
- ***Dispensed Oral Medications***
- ***Sterile Trays***
- ***Durable Medical Supplies I:E: Splints, Braces, Crutches***
- ***After hours charges and Urgent Care charges***

I have read and understand that this is a legal, binding and an enforceable contract. And my signature below confirms that I have read these billing policies and my financial obligation as pertaining to this office.

Patients Name:_____
_____

Legal
Signature:_____Date:_____
_____

PLEASE REVIEW PRIVACY STATEMENT ON REVERSE SIDE