"CARING FOR OHANA, CARING FOR YOU"

AUTHORIZATION AND RELEASE

Do you have a Healthcare Advance Directive? ◯ No ◯ Yes (Please provide us with a copy)

Do you have a primary care giver? ◯ No ◯ Yes (Please provide us with their information)

Name: _____ Phone: _____

I authorize myself, and person(s) listed below, to consent to any diagnostic and or medical treatment under the instruction of the attending physician for which my dependent, the authorized person(s) listed below or I have sought care.

Name: _____ DOB: _____

Relationship: _____ Phone: _____

Signature: _____ Date: _____

I authorize Hamakua Health Center, Inc. (HHC, Inc.) to release to the named insurance company any information necessary to secure insurance payment. I also hereby authorize the use of this signature on all insurance submissions. I understand I am responsible for all charges regardless of insurance coverage. All co-pays and overdue balances are due at the time of visit.

Signature: _____ Date: _____

I authorize payment be made directly to HHC, Inc. of medical expense benefits otherwise payable to me for any services furnished to me.

Signature: _____ Date: _____

Initials: _____ I give Hamakua Health Center, Inc. permission to verify the financial and insurance information provided by me, to determine eligibility for Hamakua Health Center, Inc. services. I understand it is my responsibility to keep Hamakua Health Center, Inc. informed of any changes in my family income and insurance status.

Initials: _____ I give my consent to all groups of Hamakua Health Center, Inc. (medical, dental, behavioral, health education, case management) to share information so my family and I will receive the best continuous care.

Initials: _____ I have read and agree to the terms of the Patient's Rights and Patient Responsibilities.

The information provided is accurate and complete to the best of my knowledge and is only to be used for my treatment, billing, processing of insurance claims, and/or for qualification for services to which I may be eligible.

_____ _____

Signature (Patient/Responsible Party/Legal Guardian) **Date**

Print name, if party other than above is signing: _____

_____ _____

HHC Witness Name (Print) Witness Signature & Date

PATIENT CONSENT FORM

I give my consent and authorization to Hamakua Health Center, Inc. to release any information regarding my diagnostic/ medical treatment, and financial status to the person(s) listed below.

Name: _____ Phone: _____

Relationship: _____ DOB: _____

Name: _____ Phone: _____

Relationship: _____ DOB: _____

Patient's Signature: _____ **Date:** _____

I authorize and consent to diagnostic and/or medical treatment under the instruction of the attending physician for which my dependant or I have sought care.

Signature: _____ **Date:** _____

May we say that it is the Hamakua-Kohala Health when we contact you?

◯Yes ◯No, then what is the best way to contact you? _____

May we leave appointment reminders on your voicemail at the phone number(s) indicated on the Patient Information form?

_____ Yes _____ No, how would you like to be notified? _____

If you are under 18, and here for a confidential visit related to Family Planning services, please provide us with a phone number where we can reach you. _____