I Ola Lāhui, Inc.

1441 Kapiʻolani Boulevard, Suite 1441, Honolulu, Hawaiʻi 96814
Phone: (808) 525-6255 Fax: (808) 525-6256

Clinic Locations:

Ala Moana Building
1441 Kapi ʻolani Blvd., Suite 1802
Honolulu, HI 96814

Aiea Medical Building
99-080 Kauhale St. #C-20
Aiea, HI 96701

Kahuku Medical Center
56-117 Pualalea St.
Plantation Wing #17
Kahuku HI, 96731

NEW PATIENT INFORMATION SHEET

Patient Information

Name: _____ Social Security: ____-_____-_____

Age: _____ Date of Birth: _____ Gender: Male _____ Female _____

Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed

Address: _____

City/State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____ Are you a Veteran of the United States military? □ Yes □ No

Employment Status: □ Full Time □ Part Time □ Retired □ Not Employed

Occupation: _____ Employer: _____

Referral Source: _____ Primary Care Physician: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Insurance Information

- Primary Insurance Company: _____

  Subscriber Name: _____ Subscriber DOB: _____

  Subscriber #: _____ Group #: _____

- Secondary Insurance Company: _____

  Subscriber Name: _____ Subscriber DOB: _____

  Subscriber #: _____ Group #: _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with the insurance company listed above and assign directly to I Ola Lāhui all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not they are paid by the insurance company. I hereby authorize I Ola Lāhui to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I will notify I Ola Lāhui of any changes in the above information.

_____ _____ _____

Responsible Party Signature **Relationship to Patient (if not signed by patient)** **Date**

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Informed Consent for Treatment/Authorization Form

Consent for Treatment

I hereby agree and consent to take part in treatment with my provider, and I understand that while I expect benefits from this treatment, results are not guaranteed. I understand that I have the right to refuse treatment and discontinue at any time without moral, legal or financial obligation. If I choose, I will be provided with referrals for other qualified providers within the community. If my provider is unavailable, I understand that every effort will be made to inform me in advance, and alternative coverage will be provided.

I understand that I will be advised of the risks of any unusual procedures, and I have the right to refuse unwanted therapeutic techniques. I have the right to refuse electronic media recording of any session and that this will not occur without my prior written consent. I understand the limits of confidentiality as they have been explained to me by my provider.

I have had the opportunity to discuss all the aspects of my treatment and have had my questions answered. I understand the parameters of treatment and understand the regular attendance will produce maximum possible benefits. I agree to comply with treatment planned.

Confidentiality

Behavioral health services are provided within I Ola Lāhui by providers with varying backgrounds, including pre-doctoral interns, post-doctoral fellows and licensed psychologists. Services rendered by paraprofessionals are supervised by their respective licensed provider(s). Your service provider should identify his or her professional status and clarify with you the nature of this, the individual providing supervision and discuss any concerns you may have regarding your care.

I understand records about my care will be kept in written or computerized form and will be available to all providers participating in my overall care and treatment. All providers within I Ola Lāhui insure confidentiality of the disclosed information by their patients within the limits outlined below. In most cases, your written consent must be obtained prior to the release of any patient information. There are, however, circumstances in which your provider may be required by law to disclose information pertaining to your treatment to the authorities without your written consent. Your provider should inform you of such actions.

In general, the law protects the confidentiality of all communications between a client and a therapist, and the release of information to others about your therapy only with your written permission (see **Release of Medical Records**). However, there are exceptions where:

- Client is a danger to self / others
- Abuse or neglect of a child, elderly or disabled person
- Specific court cases or proceedings

Release of Medical Records

Authorized release of your medical records to other entities requires written consent in the form of a Release of Medical Records. However, in order to ensure proper follow-up and continuity of care, I agree that a brief summary including the nature and length of treatment may be released to my referring provider.

Insurance Authorization

I request that payment of authorized benefits be made to I Ola Lāhui on my behalf, for any services provided to me. I authorize any holder of medical and other information about me to release to Medicare and its agents, any insurance company, any other third-party payer, state medical assistance agency, or any other government or private payer responsible for paying such benefits, any information needed to determine these benefits or benefits for related services. I agree to pay for all the charges not covered by a third-party payer. I authorize a copy of this authorization to be used in place of the original.

I have read the above and understand the nature of services provided, the limits of confidentiality and release of my medical records, and charges for services.

Name of Patient: _____

Signature of Patient/Parent/Guardian: _____ Date: _____

Psychologist Signature: _____ Date: _____

HEALTH HISTORY

Full Name: _____

Age: _____ Date of Birth: _____ Place of Birth: _____

Gender: _____ Ethnic Background: _____

MILITARY AFFILIATION:

Is any member of your family in the military?

□ No (skip to MEDICAL HISTORY) **□ Yes (see below)**

If yes, please check all affiliations:	ACTIVE DUTY					NATIONAL GUARD	RESERVES	VETERAN
	Air Force	Army	Coast Guard	Marines	Navy			
Myself								
Spouse								
Parent								
Other Family Member: _____ _____								

MEDICAL HISTORY:

Current Health Status: _____

HAVE YOU HAD?	Yes	No	HAVE YOU HAD?	Yes	No
Recurrent Headache			**Epilepsy**		
Eye Problem			**Seizures**		
Ear Problem			**Dizziness**		
Nose Problem			**Fainting with exercise**		
Throat Problem			**Head Injury**		
Thyroid Disorder			**Concussion**		
Heart Murmur			**Bone Injuries**		
Heart Disease			**Joint Injuries**		
Heart Palpitations			**Stomach Problems**		
High Blood Pressure			**Intestinal Problems**		

Low Blood Pressure			**Diabetes**		
Anemia			**Eating Disorder**		
Sickle Cell			**ADD**		
Bleeding Disorders: Hemophilia/Other			**ADHD**		
Hepatitis			**Chicken Pox Vaccine**		
Kidney Disorders			**Chicken Pox Illness**		
Bladder Disorders			**Mononucleosis**		
Pneumonia			**Alcohol Abuse**		
Bronchitis			**Drug Abuse**		
Tuberculosis			**Sexual Assault**		
Seasonal Allergies/Hay Fever			**Victim of Violence**		
Asthma			**Emotional Problems-Specify below:**		

List any other major diseases, conditions or surgeries not covered above. _____

_____

_____

List any hospitalizations. _____

_____

List any medications you are currently taking. _____

_____

List any medications you are allergic to. _____

_____

HEALTH HABITS:

DO YOU USE THE FOLLOWING?	Yes	No	DO YOU USE THE FOLLOWING?	Yes	No
Caffeine			**Tobacco**		
Alcohol			**Illicit Drugs**		

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR

I Ola Lāhui, Inc.

I have read the Notice of Uses and Disclosures of Protected Health Information (the "Notice) that is posted in your office. I was informed that I may also obtain a printed copy of the Notice from my healthcare provider.

_____

Name (Print)

_____

Signature

_____

Date

I have been given the opportunity to read the notice of the Notice of Uses and Disclosures of Protected Health Information (the "Notice") that is posted in your office. I elect to decline the opportunity to do so. I was informed that I may obtain a printed copy of this Notice from my healthcare provider.

_____

Name (Print)

_____

Signature

_____

Date