BYU-H Hawaii Health Services
55-220 Kulanui Street, Bldg. 5
Laie, HI 96762-1293
Ph.: (808) 675-3510 Fax: (808) 675-3506

PATIENT INFORMATION SHEET

Patient Name:______________________________ Birth Date: ____________________
LAST FIRST MI MONTH DAY YEAR

Parent/Guardian Name (if pt. under 18 years old): ______________________________

Local/School Address:______________________________ Local Ph.: ( ) ____________

Home Address:______________________________ Home Ph.: ( ) ____________

Social Security #:_________-_______-_________ Gender: Male/Female Marital Status: ____________

Employer: ____________________ Work Ph.: ____________ BYU–H ID #: ____________

Account #: ____________

INSURANCE INFORMATION: Please fill in the appropriate insurance information.

DMBA STUDENT INSURANCE

DMBA ID #: ____________________

Name: ____________________

Birth date: ____________________

Employer: ____________________

Email address: ____________________

OTHER OR PRIVATE INSURANCE

Insurance Co.: ____________________

Policy Holder: ____________________

Policy Holder Birth date: ____________________

Policy Holder S.S. #: ____________________

Group #: ____________________

Address of Ins. Co.: ____________________

Group #: ____________________

EMERGENCY CONTACT:

In case of emergency, please notify: ______________________________ Ph.: ____________

Relationship to Patient: ______________________________

PERMISSION TO BE TREATED:

- I authorize the physicians and nurses employed by BYU–Hawaii Student Health Services to provide to me reasonable and proper medical care as defined by today's standards.
- In accordance with Act 206 1995, I understand that I may have my symptom(s) or condition listed on myprescription label. I understand that I have the right not to have my symptom(s) or condition listed on the prescription label."
- Please indicate your preference:

_____ I wish to have my symptom(s) or condition listed on my prescription label.

_____ I **DO NOT** wish to have my symptom(s) or condition listed on my prescription label.

Signature: ______________________________ Date: ____________
PATIENT, PARENT OR LEGAL GUARDIAN

BYU–Hawaii Health Services

MEDICAL HISTORY FORM

Patient Name: ____ Age: ___________ Birth date: __________________

Please print

To be completed by the patient/parent/legal guardian and reviewed by your health care provider. Information on this form and in your medical records is confidential and can only be released to a third party with your written authorization.

Past Medical History:

1. **Medical Problems:** ____
   ____
   ____
2. **Surgeries:** ____
   ____
   ____
3. **Medications:** ____
   ____
   ____
4. **Allergies:** ____
   ____
   ____
5. **Hospitalizations:** ____
   ____
   ____

Personal History:			**Explain any "YES" answers**
1. Heart disease:	Y	N	________________
2. Stroke:	Y	N	________________
3. High blood pressure:	Y	N	________________
4. Diabetes:	Y	N	________________
5. Cancer:	Y	N	________________
6. Seizures:	Y	N	________________
7. Mental Health:	Y	N	________________
8. Other:	Y	N	________________

Family History:			**Explain any "YES" answers**
1. Heart disease:	Y	N	________________
2. Stroke:	Y	N	________________
3. High blood pressure:	Y	N	________________
4. Diabetes:	Y	N	________________
5. Cancer:	Y	N	________________
6. Seizures:	Y	N	________________
7. Mental Health:	Y	N	________________
8. Other:	Y	N	________________

OFFICE POLICIES

OFFICE HOURS

Health Services is open Monday through Friday between the hour of 8:00 a.m. – 12:00 p.m. and 2:00 p.m. – 5:00 p.m. Patient appointments are scheduled during these times.

APPOINTMENTS

- Patients are seen by appointment only. Walk-in patients will be scheduled for an appointment upon availability. If you require immediate medical attention, please call Health Services as early in the day as possible so that arrangements can be made to accommodate your health care needs.
- If you are unable to keep your scheduled appointment, please let us know as far in advance as possible. Your thoughtfulness will allow us to accommodate other patients who may wish to be seen.

BILLING OF SERVICES AND CLAIMS FILING

Charges for services are billing monthly. Health Services participates with the following insurance carriers:

- **DMBA Student Plan** – You are required to pay a $10 copayment at the time of service.
- **DMBA Choice** – You are required to pay a $15 copayment at the time of service.

Insurance payments for these plans will be made directly to Health Services. Any amount due after insurance payments have been posted will be billed to you. Our participation with these insurance companies does not guarantee insurance payment. Payment is expected at the time of billing.
You are financially responsible for any services rendered at Health Services that are denied payment from your insurance company. You must pay your balance in full by the end of each semester.

MEDICATION REFILLS

- Health Services requires 24 hours' notice for refill requests, except in cases of emergency.
- If you are on routine medications, please check your medication supply before ordering refills to make sure you have enough medication to last 48 hours prior to ordering.

IN CASE OF EMERGENCIES

Health Services is closed in the evenings, weekends and holidays. For life-threatening emergencies when Health Services is closed, go immediately to the closest emergency room or call 911 to request an ambulance. The closest emergency room is Kahuku Medical Center. If after-hour urgent medical advice is needed, please call the BYU – Hawaii Safety Office at 675-3911 for assistance reaching the after-hour advice nurse.

NOTICE OF CONFIDENTIALITY PRACTICES

This notice deals with the sharing of information from your medical records. PLEASE READ CAREFULLY.

This notice describes your confidentiality rights as they relate to information from your medical records and explains the circumstances under which information from your medical records may be shared with others. The information in this notice also applies to others covered under your health plan, such as your spouse or children. If you do not understand the terms for this notice, please ask for further explanation (Chapter 323c HRS).

- YOUR RIGHTS

  Under the new HIPPA law, you have the right to:

  1. Inspect and request copies of your medical records or to appeal any denial of your request for inspection or copying.
  2. Request that your health care provider append information to your medical record.
  3. Receive a notice of your privacy rights by your health plan upon enrollment, annually and when their confidentiality practices are substantially amended.
  4. Obtain a copy of this office's confidentiality practices.

- USES OF INFORMATION

  This office uses your protected health information to provide you with health care services. Under the law, your health information may also be used by such entities as health plans for the following purposes.

  1. Payment to physicians and hospitals who provide you with health care.
  2. Conducting quality assurance activities or outcomes assessment.
  3. Reviewing the competence or qualification of health care professionals.
  4. Performing accreditation, licensing or credentialing activities.
  5. Analyzing health plan claims or health care records data.
  6. Evaluating provider clinical performance.
  7. Carrying out utilization management.
  8. Conducting or arranging auditing services in accordance with statute, rule or accreditation requirements.

  Except for the purposes outlined above, your health information may not be disclosed without your authorization.

- LIMITING DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

  You have the right to limit disclosure of your protected health information if you choose to not use any health insurance or other third party payment as payment for services. In which case, you may only limit disclosure if you have advised the physician prior to the delivery of services and have paid for the health care services yourself.

I, the undersigned, state that I have read, understood and agree to all the terms listed above, **including the Notice of Confidentiality Practices**.

Signature: ____ Date: ____________________

PATIENT, PARENT OR LEGAL GUARDIAN

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE & PERMISSION TO RELEASE MEDICAL INFORMATION TO PARENT(S)/SPOUSE/OTHER

FOR OFFICE USE ONLY
Patient Name: ______________________
Account #: ______________________
Date of Visit: ______________________

PRIVACY

By signing this form, you acknowledge that BYU – Hawaii Health Services has given you a copy of or have offered you a copy of the '**Notice of Privacy Practices**' which explains how your health information will be handled in various situations.

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency. If you have any questions, please feel free to talk with one of our personnel.

Check all that are true:

- ☐ I have received the BYU–Hawaii Health Services' Privacy Notice.
- ☐ BYU – Hawaii Health Services has given me the chance to discuss any concerns and questions about the privacy of my health information.

PERMISSION TO RELEASE MEDICAL INFORMATION

I give permission to BYU – Hawaii Health Services to release information from my medical records to (print name of parent(s), spouse or other):

Name: ______________________ Relationship: ______________________

Name: ______________________ Relationship: ______________________

Signature: ______________________ Date: ______________________
PATIENT, PARENT OR LEGAL GUARDIAN (if signed by other than individual, state relationship)

BYU–Hawaii Health Services staff should complete if Acknowledgement Form is not signed:

1. Does patient have a copy of the Privacy Notice? ☐ Yes ☐ No
2. Please explain why the patient was unable to sign an Acknowledgement Form:

____
____
____

Signature: ______________________ Date: ______________________
Health Services Staff Member