WAIMĀNALO HEALTH CENTER

Patient Registration: TEEN CLINIC

PATIENT INFORMATION

Legal Last Name	First Name	M.I.	Preferred Name	Date of Birth

Legal Sex (Please CHECK ONE)* ☐ Male ☐ Female ☐ Choose not to disclose

*Sex assigned at birth (Male and Female). Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing, and correspondence.

Home Address	City	State	Zip Code
Mailing Address	**City**	**State**	**Zip Code**

Please complete and indicate your preferred contact method by CHECKING ONE of the boxes below:

☐ Home Phone ( ) -	☐ Cell Phone ( ) -	☐ Day Phone ( ) -	☐ E-Mail Address

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Do You Need An Interpreter? ☐ Yes ☐ No

Primary or Preferred Language: ☐ English ☐ Other: _____

Housing Status: ☐ Not Homeless ☐ Homeless: ☐ Doubling Up ☐ Shelter ☐ Street, Beach, Etc. ☐ Transitional ☐ Unreported

Ethnicity: ☐ Chicano ☐ Cuban ☐ Mexican ☐ Mexican American ☐ Puerto Rican ☐ Spanish (Or another Hispanic, Latino or Spanish Origin) ☐ Not Hispanic/Latino ☐ Not Reported

Farmer Status: ☐ N/A ☐ Migrant ☐ Seasonal

Active Military or Veteran: ☐ Yes ☐ No

Race (CHECK ONE below that best describes you):

☐ Native Hawaiian	☐ Fijian	☐ Chuukese	☐ Filipino	☐ Portuguese	☐ White
☐ Other Pacific Islander	☐ Marshallese	☐ I-Kiribati	☐ Chinese	☐ Puerto Rican	☐ Chamorro
☐ Samoan	☐ Micronesian	☐ Kosraean	☐ Japanese	☐ Other Asian	☐ African American/Black
☐ Tahitian	☐ Palauan	☐ Yapese	☐ Vietnamese	☐ Asian Indian	☐ Native American
☐ Tongan	☐ Pohnpeian	☐ Korean	☐ Laotian	☐ All Other (Please specify): _____	

Employer/School Name: ☐ Employed ☐ Unemployed ☐ Student ☐ Full-Time ☐ Part-Time ☐ Casual

Occupation:

Family Size (includes self, spouse, & children under 18): _____

Family Income: $ _____ ☐ Monthly ☐ Annual

EMERGENCY CONTACT INFORMATION

Emergency Contact Name:		Relationship:
Home Phone	**Work Phone**	**Cell Phone**

_____ Initials

I certify that the information I have furnished is true and correct to the best of my knowledge. I know it is a crime to fill out this form with facts I know are false or to leave out facts I know are important.

_____ Initials

Patient was informed of Waimānalo Health Center's Notice of Privacy Practices. Information is available on WHC's website and patient may request a hard copy at any time.

_____ Patient's Signature

_____ Date Signed

FOR OFFICE USE ONLY

Record #_____

Pt Status Type: ☐ Scheduled ☐ Active ☐ Inactive ☐ Non-WHC Active ☐ Dental Patient Only	**Valid ID:** ☐ Scan ID ☐ Update NG Pt Picture	**Insurance:** ☐ Scan Card ☐ Update Info/Card

Collected By: _____ Date: _____ Entered By: _____ Date: _____

WAIMĀNALO HEALTH CENTER

TEEN CLINIC: CONSENT FOR CARE MINOR

I agree to receive services through the Waimānalo Health Center (WHC) Teen Clinic Services. This document will be effective upon date signed, through 18 years of age, unless otherwise requested in writing to the WHC.

I understand these services include evaluation, treatment, therapy, and referrals. I understand the presence of risks and benefits to treatment and not receiving treatment, alternative treatment options, and options for a second opinion. I understand that I may ask the WHC for more information about my options.

I confirm that I am at least fourteen (14) years of age and therefore eligible to teen clinic services on my own from WHC.

I understand that the Teen Clinic is operated by WHC and certain records about my treatment shall be kept in written and computerized form and may be reviewed by other providers at WHC as needed.

I understand that information will be treated in a confidential manner. I understand that the confidentiality between myself and the WHC is assured. I understand that I can ask for more information about confidentiality at any time.

I understand that my healthcare information is confidential but that in certain situations the law allows or requires disclosure to others such as parents/guardians, school, law enforcement, government agencies, other medical providers, social services, and insurance companies if (1) I authorize the release of information, (2) a court so orders, (3) disease control for public health, (4) I present a danger to myself or others, or (5) abuse/neglect is suspected.

I understand that no teen between the ages of 14-18 years old will be denied access to health services due to their inability to pay. As in any health center, there may be a charge depending on the service(s) provided. When available, insurance will be billed. I understand that the WHC may release information regarding treatment to third party payors for billing purposes.

I understand that I may be seen by a trainee/student who is identified as such and that all services provided will be supervised by a licensed provider. I have the right to refuse to be seen by a trainee/student.

I understand that this consent is valid for my entire enrollment in Teen Clinic or until I provide the WHC staff with written directions otherwise.

Print Name of Teen Clinic Patient	Teen Clinic Patient Signature	Date

WAIMĀNALO HEALTH CENTER

APPOINTMENT KEEPING AGREEMENT

Patient Information

It is important to keep your medical appointment(s) and to be on time. At Waimānalo Health Center (WHC), our goal is to provide quality medical care in a timely manner. In our efforts to make your visit more comfortable and to minimize your wait time, we have updated and implemented the following policies and procedures.

A. Check-in Policy:

To ensure access and timeliness of medical care, the front office and medical team will inform you to arrive at your designated check-in time, to allow for registration and screening prior to your scheduled appointment time. You are encouraged to:

1. Call by 3:00 PM on the day prior to your appointment to notify us of any changes; and/or
2. If you may be late for your designated check-in time.

B. Late Arrival Policy

We understand that delays can occur, however, it is important to us to see all patients as timely as possible. Not arriving at your designated check-in time is considered late. Clock times on the WHC Front Desk computers will be used to validate ALL designated check-in times. If you arrive late for your appointment, you may experience one of the following:

1. You may be asked to wait until the provider is available.
2. You may be asked to reschedule your appointment for a later time on the same day or on a different day.
3. You may be offered an appointment with another provider on the same day, if available.
4. If no open appointments are available, you may choose to wait in case an opening arises – thought this is not guaranteed.
5. *Kukui Clinic (Behavioral Health) Only:* If you arrive late, you will be seen for the remainder of your scheduled appointment time.

C. Cancellation Policy

If you are not able to make your scheduled appointment, please call us at (808) 259-7948 by 3:00 PM on the day prior to your appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 3:00 PM on Friday. Appointments are in high demand, and your early cancellation will give another person access to timely medical care.

1. If you are not able to speak to someone, please leave a message with your name, phone number, your appointment date/time and request for rescheduling or cancellation reason.
2. If you receive appointment text reminders, you may reply with an "X" to cancel your appointment.

D. No Show Policy:

All patients who miss three (3) appointments dates in a three-month period, will be considered a chronic no show. After the third missed appointment date, you will be placed on a "Same Day Only" status. You may return to a regular status at the end of the rolling three-month period.

Waimānalo Health Center is committed to providing exceptional care. Your help in keeping your appointments enables us to provide better and timelier care for you and all of our patients.

I have read and consent to these terms.

Print Patient Name	Print Legal Guardian Name	Relationship
Patient Signature (Parent/Legal Guardian if under 18)	Date	