Mālama KIDNEY CENTER

1357 Kapiolani Boulevard, Suite 1430
Honolulu, HI 96814
Phone: 808-953-2502
Fax: 808-913-3843
Email: aloha@malamakidney.com

Patient Registration Form

Today's Date: _____

Name: _____ Birthdate: _____
(Last) (First) (Middle)

☐ Cell ☐ Home

Preferred Name: _____ Preferred Contact Method: ☐ Email ☐ Text ☐ Mail

Address: _____
(Street) (Apt #/Unit) (City) (Zip Code)

Phone: _____ _____ _____
(Cell) (Home) (e-mail)

Gender: _____ Marital Status: _____ Employer: _____
(M/F) (Single/Married/Divorced/Widowed)

☐American African ☐American Indian ☐Chinese ☐Filippino ☐Hispanic ☐Japanese ☐ Hispanic/Latino
Race: ☐Korean ☐Native Hawaiian ☐Pacific Islander ☐ White/Caucasian ☐Other: _____ Ethnicity: ☐ Non-Hispanic

Emergency Contact: _____
(Name) (Phone Number)

Please present your insurance card(s) and a picture ID for proper identification to the receptionist.

Insurance: _____ _____ _____ _____
(Name of Insurance) (Name of Subscriber) (Subscriber's Birthdate) (Relationship)

_____ _____ _____ _____
(Name of Insurance) (Name of Subscriber) (Subscriber's Birthdate) (Relationship)

I have read and agree to the following:

I hereby authorize the staff of the Malama Kidney Center to provide care management as reasonable or may be necessary in connection with the condition for which I or members of my family have sought care for myself. To the extent necessary to determine the liability of payments and to obtain reimbursement, I hereby authorize Malama Kidney Center to apply for benefits on my behalf and to release portions of my records to any person, organization, or agency which is or may be liable for any portion of the office charge. I request that all payments from the agreed third party be made directly to Malama Kidney Center and I agree to assume full responsibility of payments pending any remaining balance that is not covered by the agreed third party. I understand that my insurance covers this service, and any share of cost is due at the time services are rendered unless other arrangements are made.

MEDICARE EXTENDED AUTHORIZATION – "SIGNATURE ON FILE": I request that payment of authorized Medicare benefits be made either to me or, on my behalf, to Malama Kidney Center for any services furnished to me by members of that and its agents, any information needed to determine these benefits or benefits payable for the related services.

I understand that it is my responsibility to provide all insurance information.

Patient/Authorized Representative Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

Mālama KIDNEY CENTER

1357 Kapiolani Boulevard, Suite 1430
Honolulu, HI 96814
Phone: 808-953-2502
Fax: 808-913-3843
Email: aloha@malamakidney.com

Health History Questionnaire

Please help us get to know you better by answering the following questions about you and your lifestyle. Try to answer them as completely and honestly as possible.

Today's Date: _____

Name (Last, First): _____ Date of Birth: _____

What do you hope to accomplish with MKC? _____

_____

Is there anything you would like to improve about your health? _____

_____

What are your health goals? _____

_____

Primary Care Provider

Physician: _____ Date of Last Visit: _____

Medical History

General Health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What year were you first told you have kidney disease? _____

Do you or have you ever had any of the following: (Check all that apply): ☐ None

☐ ADHD	☐ Cancer	☐ Hearing Problems	☐ Shortness of breath
☐ Anemia	☐ Constipation	☐ Heart Disease	☐ Stroke
☐ Anxiety	☐ Decreased Appetite	☐ Hepatitis	☐ Tiredness
☐ Arm/leg swelling	☐ Depression	☐ Itching	☐ Tuberculosis
☐ Arthritis	☐ Dizziness/Fainting	☐ Liver Problems	☐ Vomiting
☐ Asthma	☐ Epilepsy/Seizures	☐ Loss of appetite	☐ Weakness
☐ Bleeding Disorder	☐ Headaches	☐ Nausea	☐ Weight increase/loss

☐ Other : _____

Hospital Visits

Have you been to the emergency room or hospital recently? ☐ Yes ☐ No Date: _____

If so, where? ☐ Queens – Punchbowl ☐ Queens – West ☐ Straub ☐ Pali Momi ☐ Kapiolani ☐ Kuakini ☐ Castle ☐ Other:

If so, why? _____

_____

Surgical History

Year	Reason	Hospital

Chronic Medical Conditions

Please respond if you have one of the following conditions:

Diabetes: ☐ Yes ☐ No First year diagnosed:_____ Managing Doctor: _____

What was your average home blood sugar reading? _____ High:_____ Low:_____

High Blood Pressure: ☐ Yes ☐ No Year diagnosed:_____ Doctor:_____

What was your average home blood pressure reading?_____ High:_____ Low:_____

Heart Disease: ☐ Yes ☐ No Year diagnosed:_____ Doctor: _____

Do you have an ICD? ☐ Yes ☐ No Do you have a pacemaker? ☐ Yes ☐ No

High Cholesterol: ☐ Yes ☐ No Year diagnosed:_____ Doctor: _____

Allergies & Medications

Do you have any allergies to medications? ☐ Yes ☐ No

If so, to what? ☐ Sulfa ☐ Anesthesia ☐ Aspirin ☐Codeine ☐ Morphine ☐ Penicillin

☐Other: _____

Do you have any non-medication allergies? ☐ Yes ☐ No

If so, to what? ☐ Adhesive Tape ☐ Latex ☐ Contrast Dye

☐Other: _____

Do you have any food allergies? ☐ Yes ☐ No

If so, to what? ☐ Nuts ☐ Eggs ☐ Cows Milk ☐Shellfish/Seafood ☐ Wheat ☐Soy

☐Other: _____

Do you have trouble taking any of your medications? ☐ Yes ☐ No

If so, please describe: _____

Personal History

Current/previous Occupation? _____

Where do you live? _____ With who? _____

Who is your support system/care giver(s)? _____

Rate the level of stress from 1 (extremely low) to 5 (extremely high):

Work: _____ Family: _____ Social: _____ Financial: _____ Health: _____

Other (please explain): _____

Health Habits and Personal Safety

Physical Activity	How physically active are you? *(Walking, running, swimming, exercise classes, yoga, etc.)* ☐ Never ☐ Monthly or less ☐ 2–4 times/month ☐ 2–3 times/week ☐ 4+/week Type of physical activity: ☐ Walking ☐ Swimming ☐ Weightlifting ☐ Gardening ☐ Sports: _____ ☐ Jogging ☐ Biking ☐ Surfing ☐ Hiking ☐ Other: _____ Does anything limit you from being physically active? _____
Diet	Do you follow a special diet/have diet restrictions? Why?*(Health, cultural, religious, etc.)* ☐ Yes ☐ No *If yes, please describe:* _____ How often do you eat out? ☐ Never ☐ Monthly or less ☐ Weekly ☐ Daily Who makes your meals? _____ Food shopping? _____ What is your favorite snack? _____ What is your favorite meal? _____
Caffeine	☐ None ☐ Coffee ☐Tea ☐Soda ☐Energy Drink ☐Other: _____ Number of cups per day: _____
Alcohol	☐ Never ☐Current ☐Former How many drinks per week: _____
Tobacco	☐ Never ☐Current ☐Former Number of years: _____ Year Quit: _____
Recreational Drug Use	☐ Never ☐Current ☐Former Number of years: _____ Year Quit: _____
Personal Safety	Do you live alone? ☐ Yes ☐ No Do you have frequent falls? ☐ Yes ☐ No Do you have vision or hearing loss? ☐ Yes ☐ No Do you have an Advance Health Directive or Living Will? ☐ Yes ☐ No

Mālama KIDNEY CENTER

1357 Kapiolani Boulevard, Suite 1430
Honolulu, HI 96814
Phone: 808-953-2502
Fax: 808-913-3843
Email: aloha@malamakidney.com

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By signing this form, I acknowledge receipt of the Notice of Privacy Practices and Patient's Rights and Responsibilities from the office of Malama Kidney Center, LLC. I understand that this office may use and disclose necessary personal health information (for example: my name, address, medical examination information, etc.) to another party to permit the office to perform its administrative duties, providing me with medical care services, process my benefit claims, and communicate with me regarding medical care services provided by this office.

I can be assured that this center does not sell my personal health information of any kind to a third party for such party's own use. I authorize the office to submit my health benefit claims to my plan sponsor or health plan to receive reimbursement directly for the medical services that I have received from this office. The Notice of Privacy Practices is subject to change. If the Notice is changed, you may obtain a revised copy on request from our staff.

Do you want to designate a family member or other individual with whom the provider may discuss your medical condition? If yes, whom?

We cannot discuss your protected health information (PHI) with anyone other than yourself unless you authorize us to do so. Please list below names(s) of the individual(s) you authorize our office to discuss your care with. Your PHI may be disclosed to the individual(s) listed below until you notify us otherwise in writing.

	Name	Relationship	Contact Number
1.			
2.			
3.			

Patient Signature **Date Signed**

Printed Name **Date of Birth**

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ The patient refused to sign.
- ☐ Due to an emergency situation it was not possible to obtain an acknowledgement.
- ☐ We weren't able to communicate with the patient.
- ☐ Other *(Please provide specific details)*

Employee signature Date

Mālama KIDNEY CENTER

1357 Kapiolani Boulevard, Suite 1430
Honolulu, HI 96814
Phone: 808-953-2502
Fax: 808-913-3843
Email: aloha@malamakidney.com

CONSENT TO EMAIL OR TEXT USAGE FOR APPOINTMENT REMAINDERS AND OTHER HEALTHCARE COMMUNICATIONS

We can now communicate you via e-mail and text to send you appointment reminders or communicate about your healthcare. If you wish to receive these messages, we require your consent. Please read the disclaimer and sign below.

I consent to Malama Kidney Center, LLC contacting me by text message and/or email for the purposes of my healthcare and appointment reminders.

I acknowledge understanding that communication by text messages and/or email are an additional service, that these may not take place on all occasions, and that the responsibility of attending appointments or cancelling them still rests with me. I understand that I can cancel this authorization at anytime by notifying the MKC Staff.

I understand that emails and text messages are transmitted over a public network onto a personal telephone/email address and as such may not be secure. However, the practice will make reasonable effort to not transmit any information which would enable an individual patient to be identified.

I agree to advise the practice if my mobile number or email address changes or if this is no longer in my possession.

Cell Phone: _____

Email Address: _____

Please select one:

- ☐ Yes, please sign me up to receive e-mail and text messaging.
- ☐ I do not wish to be contacted via email. (Text messaging only)
- ☐ I do not wish to be contacted via text messaging. (Email only)
- ☐ I do not wish to be contacted by either text messaging or email.

_____ _____

Patient Signature **Date Signed**

_____ _____

Printed Name **Date of Birth**

Mālama KIDNEY CENTER

1357 Kapiolani Boulevard, Suite 1430
Honolulu, HI 96814
Phone: 808-953-2502
Fax: 808-913-3843
Email: aloha@malamakidney.com

Mālama Kidney Center (MKC) is pleased to offer a new chronic care management service which will help us better coordinate your care for those who have 2 or more chronic conditions. Complex Chronic Care Management (CCCM) consists of non-face-to-face care services which our office will furnish to assist in coordination of your care among your different care providers and to help you better manage your chronic conditions. This service would be a complement to face-to-face services you receive, such as office visits.

As part of this service, MKC will work with a team of healthcare providers at our practice to provide care management for your chronic conditions, such as to:

- Create a comprehensive care plan, which will be made available to you either in a written or electronic format and may be periodically revised.
- Coordinate and communicate with other health professionals outside of our practice who are also involved in your care. (Please note, this communication will be done in accordance with all state and federal privacy and security laws.)
- Help you manage care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals or other health care facilities.
- Have a member of the MKC care team, accessible 24 hours a day, 7 days a week, to help you with any urgent chronic care needs and to coordinate with other healthcare professionals involved in your care.
- Review and track your key health information, laboratory results, medications and medication allergies as well as help you know when to receive recommended preventive care services.

By signing this consent form, you agree to:

- Participate in the MKC CCCM program.
- Allow MKC to bill your health insurance, including Medicare, for chronic care management services on your behalf no more frequently than once a month. This service may be billed even if you do not come into the office that month. MKC will not bill your health insurance for chronic care management during months in which less than 20 minutes of non-face-to-face chronic care management is provided.
- You understand that cost sharing (co-pay) will apply to CCCM services, so you may be billed for a portion of CCCM Services even though CCCM services will not involve a face-to-face meeting with the provider. Although there is a fee for this service, it may help you avoid the need for more costly face-to-face services that entail greater cost-sharing. Please note that only one healthcare provider can be paid for these services during a calendar month. If another provider has offered to furnish this service, please let us know.
- Authorize the electronic communication of your medical information with yourself and other treating providers as part of these care coordination efforts.

You have the right to stop receiving CCCM services at any time (effective at the end of a calendar month) and can do so by notifying us of your decision, at which point we will have you sign a CCCM termination form.

I permit MKC to bill my health insurance, including Medicare, for chronic care management services provided to me and understand I will be responsible for applicable co-payments and deductibles.

*Patient's Signature: _____
Patient/Legally authorized representative

*Printed Name: _____ Relationship to Patient: _____
*Complete only if requestor is not patient

*Date: _____

*Items must be completed for authorization to be valid

Mālama KIDNEY CENTER

1357 Kapiolani Boulevard, Suite 1430
Honolulu, HI 96814
Phone: 808-953-2502
Fax: 808-913-3843
Email: aloha@malamakidney.com

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

I authorize *_____to release the protected health information of the following:

*Patient Name: _____ Birth Date: _____

Patient Address: _____

_____

Patient Phone: _____

Patient E-mail: _____

To: *Name of Recipient: Malama Kidney Center, LLC

Address: 1357 Kapiolani Boulevard, Suite 1430
Honolulu, HI 96814

Phone: (808) 953-2502

Fax: (808) 913-3843

*Information to be disclosed:
Date(s) of Service: _____
☐ Entire Medical Record
☐ Medical Bills
☐ Other:
Please specify: _____

*Purposes of Use and/or Disclosure:
☐ Medical Care
☐ Legal purposes
☐ At request of patient
☐ Other:
Please specify: _____

_____(initial) I agree to the release of the following information should it be contained in my medical record: Acquired Immune Deficiency Syndrome (AIDS), AIDS-related complex or HIV, alcohol and/or drug abuse treatment, or behavioral or mental health services (Unless I specifically agree, the information will not be disclosed).

*Unless otherwise revoked, this authorization will expire on the following date or event: _____.
If a date or event is not specified, this authorization will expire one year from the date of my signature below.

This authorization is voluntary. I understand that the above-named health care provider(s) or health plan(s) will not condition my treatment, payment, enrollment or eligibility for benefits on the signing of this authorization excepts as allowed by law.

I understand that I may revoke this authorization at any time by notifying the above-named provider(s) and/or health plan(s), in writing, of my revocation. I understand that the revocation will not apply to any information that is already released or used in reliance on this authorization and there may be other legal restrictions on my ability to revoke this authorization. I understand that the revocation will not apply if the authorization was obtained as a condition of obtaining insurance coverage, when the law provides my insurer with the right to contest a claim under my policy or my policy itself.

I understand that the health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under the federal privacy regulations.

I release the above-named health care provider from all liability and claims whatsoever pertaining to the disclosure of information as contained in the records release pursuant to this authorization.

*Requestor's Signature: _____
Patient/Legally authorized representative

*Printed Name: _____ *Relationship to Patient: _____
*complete only if requestor is not patient

*Date: _____

*Items must be completed for authorization to be valid