Hawaii Dermatology and Plastic Surgery Centers

Name:_____ _____ _____
Last First MI

Address: _____

City: _____ State: _____ Zip Code: _____

Cell:_____Work:_____Home Phone: _____

Email Address:_____ Interested in Cosmetics? Y N

Date of Birth:_____/_____/_____ Gender: F M Marital Status: S D M W
Month Day Year

Social Security No:_____-_____-_____Employer: _____

Primary Physician:_____Referred by: _____

Emergency Contact:_____Relationship:_____Phone:_____

Party Responsible for Payment: Medical Insurance Self Pay Medical Self-Pay Cosmetic

Name of Responsible Party (If not self): _____

Address: _____

City:_____State:_____Zip:_____Phone:_____

Primary Insurance Carrier:_____Plan No.:_____

Insured Party: Self Spouse Parent Other:_____

Name (if other than self):_____Gender of Insured Party: F M

Date of Birth of Insured Party:_____/_____/_____ID/SS#_____

Secondary Insurance Carrier:_____Plan No.:_____

Insured Party: Self Spouse Parent Other :_____

Name (if other than self):_____Gender of Insured Party: F M

Date of Birth of Insured Party:_____/_____/_____ID/SS#_____

Do you have any other insurances? Y N If yes, Please list below.

Signature: _____ Date: _____

I hereby authorize the release of any medical information necessary to process claims pertinent to my care and I authorize my insurer to make direct payment to Hawaii Dermatology & Plastic Surgery Centers, Inc.

Honolulu - Hawaii Kai 6700 Kalaniana'ole Highway, Suite 217, Honolulu, HI 96825
KAILUA - Pali Palms 970 N. Kalaheo Avenue, Suite C-108, Kailua, HI 96734
KAILUA - Medical Arts 407 Uluniu Street, Suite 314, Kailua, HI 96734
Tel: 808.218.7889 Fax: 808.218.7891
www.hawaiiderm.com

Hawaii Dermatology and Plastic Surgery Centers

Patient Privacy Information and Agreement of Financial Responsibility

The purpose of this agreement is to assist you in choosing services, treatments, or laboratory tests performed or ordered by any staff member employed by Hawaii Dermatology & Plastic Surgery Centers, Inc. which your insurance carrier may not cover and to disclose our policy on privacy practices.

We believe that the patient-physician relationship is based on trust and the confidentiality of communication. The free and uninhibited disclosure of personal information within this relationship is the cornerstone of good medical care. The privacy of your medical records is of the utmost importance. Therefore, our staff has received education and training regarding the use of patients' protected health information: Your records are secured in a locked facility during non-office hours with access to office keys limited to staff of this facility. Access to electronic information is secured via passwords and your private medical information is only released as required or permitted by state and federal law.

In order to provide personalized service to our patient and function effectively, we frequently utilize outside services such as consultants. Your name, status, and location may be revealed in these settings. Laboratory test results, biopsy reports, and/or consultant reports may be shared with physicians participating in your medical care. Confidentiality can be expanded to exclude information issued to insurance companies by choosing not to use any health insurance or third-party payment for services.

As a courtesy, we will file your insurance claim for you. If your insurer rejects payment you will be responsible for these charges. Certain procedures such as skin tag removal, seborrheic keratosis removal, mole biopsy, acne surgery, laser procedures, botulinum toxin injection, and/or photodynamic therapy may not be covered by your insurance plan. It is your responsibility to provide our office with current insurance information, subscriber number, and insurance mailing address. You are also responsible for following up with your insurer about any benefit questions. If you are in an HMO plan, it is your responsibility to have a current referral from your primary care manager/physician and to have a current authorization from your insurance company on file with us. Our office is not responsible for unauthorized visits or treatments and unfortunately, you will be billed directly for these charges.

If your account is over 90 days old with no payment activity, we must regrettably turn your account over to a collection agency. To help avoid this, please be sure to pay at the time of the visit or mail in your payment by the due date. If required by your insurer, your co-payment amount is requested at the time of your visit. We accept cash, checks, and credit cards. There will be a $25 service charge for all returned checks. We can help you to arrange a monthly payment plan agreement if you prefer. Please ask one of our staff if you would like to make such arrangements.

As a courtesy to other patients and our staff, we ask that you cancel 24 hours ahead of time if you cannot make it to the appointment. We understand that there may be circumstances beyond your control that might make it difficult or impossible to show up for your appointment. Please let us know by calling 808-218-7889. We understand that sometimes you may be delayed; however, please note that late arrivals may require rescheduling. Our policy is that if you are more than 15 minutes late, we will do our best to accommodate you to be seen as soon as possible, realizing that other scheduled patients who are on time for their appointments will be given priority. There is a $40 no-show charge for patients who do not cancel a scheduled appointment. Once collected, the $40 no show fee may be applied to future co-payments, deductibles, or cosmetic procedures. There is no cash value to the no show fee and may only be used within Hawaii Dermatology Centers.

By signing below, you are acknowledging that you understand this financial agreement and further agree to pay any/all remaining balances due for your services, treatments, and/or lab tests rendered at Hawaii Dermatology & Plastic Surgery Centers within 30 days of receiving your billing statement.

Patient's Name: _____ Date of Birth: ____/____/____
Month Day Year

Name of Sponsor/Guardian if applicable: _____ Relationship: _____

_____ _____
Signature of Patient/Sponsor or Guardian Date and Time

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COVID-19 Disclaimer Agreement

I _____agree to notify the practice staff within 14 days before or after my scheduled appointment if I or someone in my household begins to exhibit COVID-19 symptoms, has been in close contact with a COVID-19 case, has been advised to quarantine by a doctor or public health official, or if I have returned from travel outside of Hawaii and am not granted an exemption from quarantine by the State of Hawaii.

Hawaii Dermatology Centers, Inc. completes internal contact tracing. All patients that are considered close contacts to other infected patients or staff will be notified by practice staff immediately.

_____

Signature Date

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MEDICAL HISTORY

Name: Date of Birth: Date:

Please list any medical conditions from which you currently suffer (heart, lung, etc.):

Please list other medical conditions from which you have suffered in the past:

Please list any surgeries (operations), reason for the surgery, and date of surgery:

ALLERGIES OR ADVERSE DRUG REACTIONS? Please list drug and type of reaction:

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Medication History

HAWAII DERMATOLOGY AND PLASTIC SURGERY CENTERS

Please Indicate if RX , OTC, Herbal Vit/Min/dietary	Name of Medication	Dosage	Frequency	How do you take this medication?
example: OTC	*example: Advil*	*example: 200mg x 3*	*example: 3 times a day*	*example: Orally With meals*

PLEASE LET US KNOW IF YOU NEED AN ADDITIONAL SHEET(s) TO LIST ALL MEDS/SUPPLEMENTS/VITAMINS/OTC DRUGS

ePrescribing is a way for doctors to send electronically an accurate, error free and understandable prescription from the office to the pharmacy. Utilizing ePrescribing provides our offices with information on which drugs are covered by your benefit plan. ePrescribing provides us with information on your current and past prescriptions to allow us to be better informed about potential medication issues.

I consent to allow Hawaii Dermatology to request and use my prescription medication history from pharmacy benefit registrations for documentation and treatment purposes.

Printed name _____ Signature _____ Today's Date _____