

HAWAII EAR CLINIC, INC. - OTOLOGY, NEUROTOLOGY, & SKULL BASE SURGERY

Patient's Name: _____ Preferred Pharmacy: _____

Date of Birth: ____ / ____ / ____ Sex: Male Female Email: _____

Race: (check one) American Indian/Alaska Native Asian Black African/African American White
 Hawaiian/Pacific Islander Other Race Unknown Declined

Ethnicity: (check one) Hispanic/Latino Non-Hispanic/Non-Latino Declined Unknown

Marital Status: Single Married Divorced Widowed Partner

Phone: Home () _____ - _____ Bus. () _____ - _____, Ext _____ Cell () _____ - _____

Home Address: _____
Street Address City State Zip Code

Billing Address: Same as home address Address Below: Responsible Party Name: _____

Street Address City State Zip Code

Referral source/physician: _____ Primary care physician: _____

Employer: _____ Occupation: _____

PRIMARY INSURANCE COVERAGE: _____ Subscriber's Name: _____

Subscriber's ID#.: _____ Group#.: _____ Subscriber's Date of Birth: ____ / ____ / ____

Sex: M F Relationship to patient: Self Spouse Father Mother Legal guardian Domestic Partner

SECONDARY INSURANCE COVERAGE: _____ Subscriber's Name: _____

Subscriber's ID#.: _____ Group#.: _____ Subscriber's Date of Birth: ____ / ____ / ____

Sex: M F Relationship to patient: Self Spouse Father Mother Legal guardian Domestic Partner

Emergency Contact: _____ Phone: () _____ - _____
Name Relationship

Insurance Policy

All of the questions answered herein are true and correct to the best of my knowledge. I understand and accept responsibility for the payment of all services rendered by Hawaii Ear Clinic Inc. I further understand that should any of the insurance carriers that I have named herein as responsible for the payment of medical services for any visit refuse to pay for any/all of the services rendered by Hawaii Ear Clinic Inc., I will be responsible for the payment in full of all medical treatment and services rendered. I also understand that should Dr. Hadley be a non-participating provider of my insurance, it will remain my responsibility to ensure that the proper authorization be in place at the time of my visit. If the authorization is not received at the time of my appointment, I agree that should my insurance not cover the visit, I will pay out of pocket for any and all visits rendered by Dr. Hadley and or Hawaii Ear Clinic.

No Show Policy

To better serve our patients, we have implemented a "NO SHOW" policy effective February 10, 2015. Should you fail to keep your scheduled appointment with Hawaii Ear Clinic, there will be a \$25.00 non-refundable charge applied to your account and must be paid in full before a new appointment is scheduled. Should you "NO SHOW" for a total of 3 appointments, you will hereby be discharged from our office and will be sent written notice in the mail confirming discharge from Hawaii Ear Clinic, Inc.

Grounds for Termination

We may terminate a relationship with a patient at any time by giving 30 day written notice during which time the physician is responsible only for responding to urgent medical matters. Dr. Hadley will reserve this action for patients who demonstrate a lack of respect for themselves and our staff, by repeatedly missing appointments, failing to pay their bills and/or disregarding the stated polices of the practice.

This document, by my signature, shall also authorize Hawaii Ear Clinic Inc., to release any and all medical information pertaining to my condition to insurance carriers, claims adjusters and attorneys involved in my claim either by virtue of providing payment for services rendered or by legal representation. This document also authorizes Hawaii Ear Clinic to obtain pharmacy benefit and medication information electronically. This authorization shall remain in effect for the duration of my treatment time with Hawaii Ear Clinic Inc.

Signature of Patient or Legal Guardian

Date Signed

Printed Name of Legal Guardian: _____

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Notice of Privacy Practices

This notice describes how health information about you (as a patient of this practice) may be used & disclosed, & how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability & Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize these laws are complicated, but we must provide you with the following important information:

Use and disclosure of your health information in certain special circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities & health oversight agencies that are authorized by law to collect information.
2. Lawsuits & similar proceedings in response to a court or administrative order.
3. If required to do so by law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health/safety or the health/safety of another individual or the public. We will only make disclosures to a person or/organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) & if required by the appropriate authorities.
6. To federal officials for intelligence & national security activities authorized by law.
7. To correctional institutions/law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation & similar programs.

Your rights regarding your health information

1. Communications: You can request that our practice communicate with you about your health & related issues
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care or the payment for your care, such as family members & friends. We are not required to agree to your request; however, if we do agree, we are bound by agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records & billing records, but not including psychotherapy notes. You must submit your request in writing to the Compliance Officer for our company.
4. You may ask us to amend your health information if you believe it is incorrect or incomplete, & as long as the information is kept by our practice. To request an amendment, your request must be made in writing & submitted to our Compliance Officer. You must provide us with a reason that supports your request for amendment.
5. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact our Compliance Officer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.
7. Right to provide an authorization for other uses & disclosure. Our practice will obtain your written authorization for uses & disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact our Compliance Officer.

I hereby acknowledge that I have read & understood the Notice of Privacy Practice Policies of Hawaii Ear Clinic, Inc.

Signature of Patient/Guardian: _____

Patient's Name (Print): _____

Date: _____