# Patient Registration Form

Please print clearly. All information will be confidential.FIELDS MARKED
* REQUIRED FOR PRESCRIPTION AND BILLING PURPOSES

Name* ________________________________________________

Birthdate* ____/____/______ SSN* ________________________ Gender Male Female

Street Address* __________________________ City________________ State _____ Zip code __________

Mailing Address* ________________________ City________________ State _____ Zip code __________

Same as above

Primary Phone* ______________________ Cell phone Home phone

Alternate Phone ______________________ Cell phone Home phone

Email Address ___________________________________________________________________________

Preferred method of contact*: Call Text Email No Preference

Marital Status: Single Married Separated Divorced Widowed

Emergency Contact ___________________________ Relationship ________________ Phone _____________

Approved Contact ____________________________ Relationship ________________ Phone _____________
*By approving this contact, you are allowing this person access to all your PHI information.

Race/Ethnicity (check one of the following) :

American Indian or Alaska Native
Native Hawaiian
African American
Asian
Caucasian
Hispanic
Other Pacific Islander
Other Race
Prefer not to say

Preferred Pharmacy* ________________________________ Location: __________________________

Primary Physician* __________________________Referring Physician ______________________________

Patient's Employer ____________________________________________Work Phone __________________

Business Address __________________________ City__________________ State _____ Zip code ________

Kihei, Maui Office
221 Piikea Ave, #8268
Kihei, HI 96753

Kaneohe, Oahu Office
46-001 Kamehameha Hwy, # 212
Kaneohe, HI 96744

**Primary Insurance Carrier:** ____________________________________

Name of Insured*_________________________________Relationship to patient* _________________

Insured's Birthdate* _____/_____/______ SSN* __________________________

Street Address __________________________ City_______________ State ____ Zip code ________

Mailing Address _________________________City_______________ State ____ Zip code _______
same as above

Phone* ____________________ Cell Home Email Address _________________________

Do you have additional insurance? Yes No If yes, complete the following

**Secondary Insurance Carrier:** ______________________________________

Name of Insured*_________________________________Relationship to patient* _________________

Insured's Birthdate* _____/_____/______ SSN* __________________________

Street Address __________________________ City_______________ State ____ Zip code ________

Mailing Address _________________________City_______________ State ____ Zip code _______
same as above

Phone* ____________________ Cell Home Email Address _________________________

## Please Pay Co Payments at Time of Service

Charges such as co-pays, co-insurance payments and deductibles are also due at time of service. For those patients having procedures covered by insurance plans, we will file a claim to your primary insurance carrier to receive payment for your visit. Please note, if your health insurance plan does not provide reimbursement of the claim within 60 days after your appointment the unpaid balance will become your responsibility.

I have read and understand this document and agree to abide by its terms. All of my questions regarding this document have been explained to me. I understand that charges not covered by my health insurance plan, or not paid to Hawaii Heart Associates doing business as Ryan M. Smith, DO, FACC within 60 days of the service rendered, as well as any applicable fees, co-payments, and deductibles, are my responsibility.

I certify that the information provided is true and correct to the best of my knowledge and belief and I understand and agree that I have a continuing obligation to advise Hawaii Heart Associates if there is a change in circumstances.

Patient or Guarantor Signature: _________________________ Date:______________

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# HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. “Protected health information” is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

**Uses and Disclosure of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of the office that are involved in your care, for the purpose of providing healthcare services to you, to pay your health care bills, to support the operation of the physician’s practice, and any other use required by law.

**Treatment**

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment**

Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Healthcare Operations**

We may use or disclose, asneeded, your protected health information in order to support our practice’s activities, training of medical students, and licensing. For example, we may disclose your protected health information to medical school students that see patients at our office. In our day-to-day practice activities, we may use a sign-in sheet at the registration desk, we may also call you by name in the waiting room when your physician is ready to see you. Your protected health information may also be used to contact you to remind you of an appointment.

**Uses of Disclosure of Protected**

Hawaii Heart Associates may make disclosures of your protected health information to or regarding the following when required by law.Your Rights to Privacy Your medical information will not be shared and/or disclosed to

anyone without your permission except asdescribed in this notice or required by law. You may, in writing, revoke this authorization at any time. You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

You have the right to inspect and copy your protected health information. If you request a copy of the information, we may charge a reasonable fee for the cost of copying, mailing or other supplies associated with your request. Under federal law, however, you may not inspect or copy psychotherapy notes; information completed in reasonable anticipation of, or use in a civil criminal, or administrated action or proceeding, and protected health information that is subject to law that prohibits health information. You also have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information, as well as extra copies of this notice.

You have the right to request a restriction or an amendment of your protected health information. This means that you ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restrictions requested and to whom you want the restriction to apply. Please note, your physician is not required to agree to a restriction or amendment that you may request if they believe it is in your best interest. You then have the right to use another healthcare professional or file statement of disagreement with us.

**Complaint**

You may complain to us or to the Secretary of Health and Human Services if you have concerns about your privacy. We will not retaliate against you for filing a complaint. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. This notice became effective April 14, 2003.

Print Name: ____________________________________________

Signature: _____________________________________________

Date: _________________________________________________

Signature is only acknowledgement that you have received this notice of our Privacy Practices.

# Records Release

To: ______________________________________________________________

Fax:______________________________________________________________

Telephone:_________________________________________________________

Date:_____________________________________________________________

I authorize Dr. Ryan Smith to release or receive records from my medical physician(s) or medical facilities in order to have continuity of my care

Printed Name:______________________________________________________

Signature: _________________________________________________________

Date of birth:_______________________________________________________

Witness:___________________________________________________________

Comments:

__________________________________________________________________

__________________________________________________________________

__________________________________________________________________

__________________________________________________________________

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