Blane K. Chong
Family & Sports Medicine
3221 Waialae Avenue, Suite 390
Honolulu, HI 968816
Ph 808.732.9710
Fax 808.732.9720

REGISTRATION FORM

Today's Date:	PCP:

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐

Is this your legal name?	If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:
☐ Yes ☐ No					☐ M ☐ F

Street address:	Social Security no.:	Main phone no.:
		( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:
		( )

Ethnicity:	☐ Hispanic or Latino	☐ Not Hispanic or Latino	☐ Decline

Race:	☐ White	☐ Black or African American	☐ American Indian or Alaska Native	☐ Asian	☐ Native Hawaiian or Pacific Islander	☐ Decline

Language:

In Case of Emergency:

Full Name:	Relationship to patient:	Cell phone no.:	Home phone no.:

INSURANCE INFORMATION

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
			( )

Is this person a patient here?	☐ Yes	☐ No	Is this patient covered by insurance?	☐ Yes	☐ No

Is this patient covered by insurance?	☐ Yes	☐ No	Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Policy no.:	Co-payment:
				$

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

Name of secondary insurance (if applicable):	Subscriber's name and birth date:	Telephone no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

ALLERGIES	
List any/all known allergies: ☐ No Known Allergies	

MEDICATION HISTORY	
List any/all medications: ☐ No Known Drug Allergies	

ACTIVE PROBLEMS	
List any active medical problems:	

PAST MEDICAL HISTORY	
List any past medical problems:	

PAST SURGICAL HISTORY	
List any past surgical procedures:	

FAMILY MEDICAL HISTORY	
Please list family member relationship with medical history:	1.
	2.
	3.
	4.
	5.
	6.
	7.

SOCIAL HISTORY		
Tobacco Use:	☐ Current Every Day Smoker	☐ Current Some Day Smoker
	☐ Former Smoker : Date Quit:_____	☐ Never A Smoker
Alcohol Use:	☐ Current Alcohol User ☐ Social ☐ Occasional	Frequency _____/day _____/week
	☐ Never Drank Alcohol	☐ Stopped Drinking Alcohol

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance whether or not paid by said insurance. I understand that I will be assessed the bank charge for each check returned due to insufficient funds. In the event of default, I (We) promise to pay legal interest on the indebtness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. I also authorize Blane K. Chong, M.D., or its representatives, TeamPraxis, or insurance company to release any information required to process my claims, including the diagnosis and the records of any treatment or examination rendered to me during this period of such medical or surgical care. I hereby, assign all medical/surgical benefits to include major medical benefits to which I am entitled, including Medicare, Triwest, private insurance, and any other health plan to Blane K. Chong, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I authorize & approve my signature as an electronic signature. I hereby authorize Blane K. Chong, M.D. to release all information necessary to secure payment and treatment.

CONSENT TO TREATMENT

I authorize and Consent to medical care and treatment with Blane K. Chong, M.D. that my treating physician finds to be necessary and which is given or performed at his direction. I understand that any requests or restrictions related to my treatment must be discussed with my physician.

FINANCIAL AGREEMENT

Assignment of Insurance Benefits and Payment:

I understand that I am responsible for paying my bill in full. If I am entitled to any insurance benefits, I assign all of these benefits to Blane K. Chong, M.D. toward payment of my bill and direct my insurance carrier to pay these benefits to Blane K. Chong, M.D. Blane K. Chong, M.D. will bill my insurance carrier if I provide the appropriate information in a timely fashion.

NO SHOW POLICY

After the 1st No Sow visit, a letter will be sent in regards to our No Show policy stating that a $25 fee will be charged for each No Show visit following the initial No Show. I understand that I am responsible for paying the fee in full and this cannot be billed to my insurance.

Collection:

If the bill is not paid within 90 days (or longer if required by law), I understand that Blane K. Chong, M.D. may refer the matter to an attorney and/or collection agency and that I will be responsible for paying all legal fees and other costs incurred to collect my bill.

If I have CHAMPUS coverage:

I request payment to Blane K. Chong, M.D. of authorized benefits for all services furnished me by Blane K. Chong**.**

If I have Medicare coverage:

I certify that the information given to me in applying for payment under Medicare is correct. I authorize the Social Security Administration to release information on my Medicare effective dates and Medicare Claim number to Blane K. Chong, M.D. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any information needed for this or any related Medicare claim. I request that payment of benefits be made to Blane K. Chong. M.D. on my behalf.

NOTICE OF PRIVACY PRACTICE

My signature below will confirm that I have been given a copy of the Blane K. Chong, M.D. Notice of Privacy Practice.

RELEASE OF INFORMATION:

I understand that my health information for this course of treatment may be disclosed for the purpose of treatment, for obtaining payment from my insurers and other payors, and for other qualified health care operations, within the limits of the law. I further understand that certain specific categories of my health information require Consent before release. If my medical records for this course of treatment contain any information related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), mental health diagnosis and treatment, and/or treatment in a federally funded substance abuse treatment program. I Consent to release such health information for the purpose of treatment, for obtaining payment from my insurers and other payors, and for other specific insurer/payor requirements, within the limits of the law.
I certify that I have read this Consent and that I am the patient, or the patient's authorized representative, and I accept and agree to be bound by the Consent, a copy of which will be made available upon request.

Patient/Guardian signature *Date*

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PROVIDER PARTNERSHIP AGREEMENT

Dear Patient,

Welcome and thank you for choosing my practice. I am committed to providing you with the best medical care based on your health needs. My hope is that we can form a partnership to keep your whole self as healthy as possible, no matter what your current state of health.

Your commitment to my patient-centered medical home practice will provide you with an expanded type of care. I will work with both you and other health care providers as a team to take care of you. You will also have better access to me through phone and patient portal.

As your primary care provider, I will:

- Learn about you, your family, life situation, and health goals and preferences. I will remember these and your health history every time you seek care and suggest treatments that make sense for you.
- Take care of any short-term illness, long-term chronic disease, and your all-around well-being.
- Keep you up-to-date on all your vaccines and preventive screening tests.
- Connect you with other members of your care team (specialists, health coaches, etc.) and coordinate your care with them as your health needs change.
- Be available to you after hours for your urgent needs.
- Notify you of test results in a timely manner.
- Communicate clearly with you so you understand your condition(s) and all your options.
- Listen to your questions and feelings. I will respond promptly to you – and your calls – in a way you understand.
- Help you make the best decisions for your care.
- Give you information about classes, support groups, or other services that can help you learn more about your condition and stay healthy.

We trust you, as our patient, to:

- Know that you are a full partner with us in your care.
- Come to each visit with any updates on medications, dietary supplements, or remedies you're using, and questions you may have.
- Let us know when you see other health care providers so we can help coordinate the best care for you.
- Keep scheduled appointments or call to reschedule or cancel as early as possible.
- Understand your health condition: ask questions about your care and tell us when you don't understand something.

- Learn about your condition(s) and what you can do to stay as healthy as possible.
- Follow the plan that we have agreed is best for your health.
- Take medications as prescribed.
- Call if you do not receive your test results within two weeks.
- Contact us after hours only if your issue cannot wait until the next work day.
- If possible, contact us before going to the emergency room so someone who knows your medical history can care for you.
- Agree that all health care providers in my care team will receive all information related to your health care.
- Learn about your health insurance coverage and contact your insurance if you have any questions about your benefits.
- Pay your share of any fees.
- Give us feedback to help us improve our care for you.

If at any time we feel this agreement is not being met, our office reserves the right to discontinue treatment. If you as patient feel this agreement is not being met, you also have the right to discontinue treatment provided by our office and transfer care to a provider of your choice.

I look forward to working with you as your primary care provider in your patient-centered medical home.

Provider Signature	Printed Provider Name	Date
_____	_____	_____
Patient Signature	Printed Patient Name	Date
_____	_____	_____
Parent/Guardian Signature	Printed Parent/Guardian Name	Date
_____	_____	_____

* Cell Phone Number _____

* Email Address _____

* By providing your cell phone number and/or email address, you consent to your PCMH care team contacting you regarding your medical care via cell phone or email.

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Authorization for Verbal Communication

This does not authorize release of copies of medical records without a signed Authorization to Release Medical Records form by patient or guardian.

Patient Information

Name- (Last, First, MI)	Date of Birth:
Address:	

Current Telephone numbers

Home Phone:	Cell Phone:
Work Phone:	Other Phone:

Your protected Health Information Designees:
If you are not available at the time we call, please list those individuals (designees) below with whom we can leave a brief message with or discuss any medical information (e.g. lab results, prescription refills, etc). This designee will also be able to contact our office directly on your behalf.

Please print the name and relationship to you of each designee below:

Designee Name:	Relationship to patient:	Contact #:
Designee Name:	Relationship to patient:	Contact #:

Confidential Voice Mail:
Please initial below where we have your permission to leave confidential voice mail regarding any medical information (e.g. lab results, prescription refills, etc.)

Home Phone _____ Cell Phone_____ Work Phone_____ Other Phone_____

____ Initial here if you ***do not want*** us to discuss your medical information with anyone other than yourself.

Your signature below confirms your approval of these updated HIPPA communication preferences. You may change your selections at any time, but must do so by completing an updated form.

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN DATE SIGNED