



HAWAII GASTROENTEROLOGY SPECIALISTS

98-211 Pali Momi Street, Suite 312, Aiea, HI 96701

P: (808) 486-0449
F: (808) 488-0725

CONFIDENTIAL INFORMATION

Office Use Only: Account #: _____

PATIENT INFORMATION

Patient Name: _____ Nickname: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Marital Status: Single Married Other: _____

Social Security #: _____ Gender: Male Female

Home Phone#: _____ Cell Phone#: _____ Work Phone#: _____

Email: _____ Personal Work

Referred By Dr./Nurse: _____ Primary Care Specialist

PATIENT EMPLOYMENT Employment Status: Employed Retired Other: _____

Employer: _____ Occupation: _____

Address: _____ City: _____ State: _____ Zip: _____

EMERGENCY CONTACT

Name: _____ Relationship to you: _____

Phone #: _____ Alternate #: _____

LEGAL HEALTH CARE DECISION MAKER

Do you have an "Advanced Health Decision Maker" or "Power of Attorney"? Yes No

If so, who should we contact? _____ Relationship: _____

Phone #: _____ E-mail: _____

I have completed the above information to the best of my knowledge. I will notify the office of any changes in my health status or in any of the above information.

Signature of Patient/ Legal Guardian: _____

Today's Date: _____



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FINANCIAL INFORMATION

PRIMARY INSURANCE COMPANY

Relationship to Subscriber: Self Spouse Other: _____

Insurance Company: _____ Policy #: _____

Subscriber's Name: _____ Subscriber's Birth Date: _____

Subscriber's Gender: Male Female Group #: _____

SECONDARY INSURANCE COMPANY

Relationship to Subscriber: Self Spouse Other: _____

Insurance Company: _____ Policy #: _____

Subscriber's Name: _____ Subscriber's Birth Date: _____

Subscriber's Gender: Male Female Group #: _____

OTHER INSURANCE COMPANY

Relationship to Subscriber: Self Spouse Other: _____

Insurance Company: _____ Policy #: _____

Subscriber's Name: _____ Subscriber's Birth Date: _____

Subscriber's Gender: Male Female Group #: _____

PERSON RESPONSIBLE FOR PATIENT'S MEDICAL BILLS, IF NOT THE PATIENT

Name: _____ Relationship to you: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender: Male Female

Home Phone#: _____ Cell Phone#: _____ Work Phone#: _____



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OFFICE POLICY & FINANCIAL AGREEMENT

OFFICE HOURS:

Regular office hours are from 7:30 AM to 4:30 PM Monday through Friday excluding holidays. Office visits are by appointment only. We strongly believe in the value of your time and will do our best to keep scheduled appointments running smoothly. However, emergencies do occur and may cause a delay.

TELEPHONE CALLS:

A receptionist handles incoming calls, which allows for the Physician or Physician Assistant to attend to their scheduled patients with minimum interruptions. The receptionist will transfer you to the appropriate staff member so you can leave a message for the Physician, Physician Assistant, or Medical Assistant. Your non-urgent calls will be responded to within the next business day. Prescription refills requests will be processed in three business days.

INSURANCES:

If you have insurance coverage, please understand that this is a contract between you and your insurance company. As a courtesy to you, we will help you receive your benefits by submitting medical claims for reimbursement provided that we receive all the necessary information. **PLEASE NOTE THAT SOME SCREENING PROCEDURES MAY NOT BE COVERED. CHECK WITH YOUR INSURANCE COMPANY BECAUSE YOU WILL RESPONSIBLE FOR PAYMENT IN FULL.**

MISSED APPOINTMENTS

Unless we receive a 24-hour notice of cancellation of your appointment, our policy is to charge for missed appointments at the rate of a normal office visit (\$50.00 USD). To help better serve you, please keep your scheduled appointments. If you arrive late for your scheduled appointment, we will need to reschedule you to another appointment time.

I, _____ (**print name**), understand and agree to the above policies and that, regardless of my insurance status, I am responsible for any balance on my account for professional services rendered. I have completed the above financial information to the best of my knowledge. I will notify the office of any changes in my health status or in any of the above information. My signature below also authorizes the release of information necessary to process insurance claims to my insurance company(ies) and for payment to be made directly to any of the participating medical providers at Hawaii Gastroenterology Specialists.

Signature of Patient/Legal Guardian: _____ **Date:** _____