Carla Nip-Sakamoto, MD Miki Shirakawa Garcia, MD Summer Chong, MD

1329 Lusitana Street, Suite 109, Honolulu, Hawaii 96813

CONFIDENTIAL PATIENT REGISTRATION FORM

(PLEASE PRINT)

Today's Date: / /	Primary Care Physician:

PATIENT INFORMATION

Patient's Last Name	Patient's First Name	MI	Marital Status (circle one)
			Single Married Div Widow Other

Street Address/Apt#	City/State/Zip Code	Birth Date	Age	Gender
				M F

Home Phone:	Cell Phone:	Work Phone:	SSN:	Spouse's Name:

Occupation:	Employer:

Person Responsible for Bill (Guarantor)	Date of Birth	Occupation:	Home Phone:
			Cell/Work:

Billing /mailing Address if different from above:

May we leave messages regarding your health care and services on your answering machine, including appointment reminders? Yes_____ No_____ Can we send your email regarding special promotions? Yes_____No_____	Email Address: (PLEASE PRINT LEGIBLY)

In accordance with CMS " Meaningful Use" Requirements we are obliged to gather the following information. You may decline to answer if you would rather not provide this information	Race/Ethnicity (circle): Asian African American Hispanic American Indian Caucasian Native Hawaiian/Pacific Islander Decline to Answer	Primary Languages Spoken:

INSURANCE INFORMATION

(PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST)

PRIMARY INSURANCE:

Insurance Name: _____ Insurance ID # _____

Subscriber Name: _____ Subscriber date of birth: _____

Patient's relationship to subscriber: (circle one) Self Spouse Child Other

SECONDARY INSURANCE:

Insurance Name: _____ Insurance ID # _____

Subscriber Name: _____ Subscriber date of birth: _____

Patient's relationship to subscriber: (circle one) Self Spouse Child Other

TERTIARY INSURANCE:

Insurance Name: _____ Insurance ID # _____

Subscriber Name: _____ Subscriber date of birth: _____

Patient's relationship to subscriber: (circle one) Self Spouse Child Other

IN CASE OF EMERGENCY

Name to contact in case of emergency _____

Relationship to patient: _____ Home/Work/Cell Phone Number: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Carla Nip-Sakamoto MD, Miki Garcia MD, Summer Chong MD, or the insurance company to release any information required to process my claims. To release optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for services at the time they are rendered unless you are in a prepaid health insurance in which we participate. For those patients, applicable insurance copayments and decuctibles will be collected at the time services are rendered. We accept payment in the form of cash, check and credit cards (Visa, Mastercard, Discover and AMEX).

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

PATIENT CONSENT FORM

Our Notice of Privacy Practices (the "Notice") provides information about how

Oahu Dermatology LLC (the "Practice") may use and disclose Protected Health Information about you. The Notice contains a Patient Rights section (under the heading "Your Rights Regarding Your Protected Health Information") describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, except in certain limited instances, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of Protected Health Information about you for non-subsidized treatment, payment and health care operations, and for other purposes as permitted or required by law. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected Health Information may be disclosed or used for treatment, payment or health care operations, or for other purposes permitted or required by law. However, we will obtain from you a separate written authorization for "subsidized" disclosures, meaning disclosures involving product or service with respect to which the Practice receives remuneration from a third party.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of its information but the Practice does not have to agree to those restrictions, except in certain limited instances.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

Patient Name _____ Date of Birth ___/___/_____

Signature _____

This Consent was signed by: _____

Printed Name – Patient or Representative

Relationship to Patient (if other than patient): _____

Date: _____

In front of _____

Printed name – Practice representative

Oahu Dermatology LLC
Patient Payment Policy

Oahu Dermatology LLC strives to ensure a clear understanding of your financial responsibility with respect to the services we provide. These policies apply to all consultations, office visits, surgical procedures and aesthetic procedures.

CO-PAYS: We kindly request that copayments be made at the time of your visit.

PAYMENTS: We accept cash, check and credit cards (VISA, MasterCard, Discover, Amex, and Apple Pay). In the event of a NSF (Non-Sufficient Funds) check, there will be a $25.00 NSF fee charge that will be added to your balance.

OUTSTANDING BALANCES: We require payment of your outstanding balance at the time of your visit. Failure to do so may result in a decision to postpone further visits until payment is made. Delinquent payments after 90 days will be referred to a collection agency. You will be assessed a fee of $25.00 for collection.

NO INSURANCE: If you do not have insurance, we will collect an initial office visit/consultation fee on your first visit. Fee varies depending on the nature of your visit. Please note that there may be additional charges to your visit if procedures are required.

Fees for follow-up visits are collected at the time of service.

CANCELLATIONS: Please inform us 24 hours in advance of an appointment cancellation or reschedule. If you do not call and cancel your appointment 24 hours prior to your appointment, the following fee will be added to your account balance:

- **All new and established patient office visits and surgery - $25.00**
- **Aesthetic/Cosmetic procedures - $50.00**

CLAIMS FILING: Please update and notify our office of any changes to your demographics and insurance information. Keep in mind that payment remains your responsibility. We file claims in accordance with all federal, state and contractual requirements to insurers with whom we have an agreement as a participating provider. We expect payment in full from you if your insurer denies/rejects the claim.

I have read, understand and agree to the above Oahu Dermatology LLC Payment Policy. I understand that charges not covered by my insurance company as well as applicable copayments and deductibles are my responsibility. I acknowledge that these policies do not obligate Oahu Dermatology LLC to extend credit.

_____

Print name of Patient

_____ _____

Signature of Patient (or responsible party if minor) **Date**