**URGENT CARE OF KONA / WEST HAWAII MEDICAL GROUP**
77-311 Sunset Drive, Kailua-Kona, HI 96740
808-329-6355/808-327-4357
Receptionist@whmgmail.com

# WELCOME TO OUR OFFICE

**Today's Date:**_____

Thank you for choosing our office.
In order to serve you properly we will need the following information. (PLEASE PRINT) All information is strictly confidential.

**Reason for seeing Doctor** _____

**Is this a WORK RELEATED INJURY:** Yes ☐ No ☐ **AND/ OR a MOTOR VEHICLE INJURY :** Yes ☐ No ☐

Patient's Name: _____ Male ☐ Female ☐

Cell Ph# _____ Home Ph# _____ E-MAIL: _____

Date of Birth _____ SSN _____ Marital Status: Married ☐ Single ☐

Mailing Address _____

City _____ State _____ Zip Code _____

Residence Address _____

City _____ State _____ Zip Code _____

Name of Employer _____Occupation _____ Work Ph# _____

**IF VISITING LOCAL HOTEL NAME & PHONE#:** _____

Medical Insurance Yes ☐ No ☐ If no insurance how do you intend to pay? Check ☐ Cash ☐ Credit Card ☐

Insurance Company Name _____ Policy# _____

Subscriber Name _____ Date of Birth _____

Relationship to Patient: Self ☐ Spouse ☐ Child ☐ Other ☐

Secondary Insurance _____ Policy# _____

Subscriber Name _____ Date of Birth _____

Relationship to Patient: Self ☐ Spouse ☐ Child ☐ Other ☐

## PLEASE GIVE INSURANCE CARDS TO THE RECEPTIONIST

Name of Spouse _____ Phone# _____

**IF PATIENT IS A CHILD, PARENT'S NAME:** _____

SSN _____ Date of Birth _____ Home Phone _____

Name of Employer _____ Occupation _____ Work Phone _____

Person to notify in case of emergency _____ Phone _____

**Please complete the back of this form. Thank-You**

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**AUTHORIZATION FOR TREATMENT RELEASE OF INFORMATION ASSIGNMENT OF BENEFITS AND ACKNOWLEDGE OF RESPOSIBILITY FOR PAYMENT FOR PHYSICIAN SERVICES**

I hereby give my consent to the physicians at The Urgent Care of Kona and / or West Hawaii Medical Group to provide whatever treatment is deemed necessary.

I authorize any holder of medical information to release to my insurer and it agents, physicians, hospital and other medical providers any information needed to determine benefits payable for these related services.

I hereby authorize my insurance company, including Medicare, to pay my plan benefit payments directly to the provider of service, The Urgent Care of Kona and / or West Hawaii Medical Group unless the services have been completely paid. This assignment will remain in effect until revoked by me in writing.

NOTICE TO INSURANCE:
If your insurance or PCP (Primary Care Physician) requires notification for HMO Referral or authorization of services rendered this is your responsibility.

UNDERSTANDING NON-PAR / NOT CONTRACTED:
There will be no adjustment to the allowed or eligible fee schedules for insurances with which we are not contracted, or non-participating, or non-preferred, or non-network. You will likely have a deductible and a reduced reimbursement from your insurance. Please contact your insurance if you have any questions regarding your benefits.

I understand that I am financially responsible for all charges incurred and, in the event that insurance payments are sent directly to me, I will remit payment to this office unless I have already completely paid my bill. If my insurance does not pay all bill submitted, within 60 days, I acknowledge that these bills are my responsibility and will guarantee immediate payment. I further agree to pay any reasonable cost, including attorney and collection agency cost, in the event my account becomes delinquent.

_____

Name of Responsible Party (PLEASE PRINT)

_____ _____

Signature DATE

I have been given the opportunity to review West Hawaii Medical Group / Urgent Care of Kona's Notice of Privacy Practices.

_____

Signature

YOU WILL RECEIVE A SEPARATE BILL FOR ALL SERVICES REFERRED TO AN OUTSIDE SOURCE INCLUDING BUT NOT LIMITED TO PATHOLOGY AND LABORATORIES.

_____

Signature