Annual ☐

Please check box if you are Native Hawaiian ☐ Date: _____

Ke Ola Mamo
A Native Hawaiian Health Care System
1505 Dillingham Blvd. Room 205
Honolulu HI 96817

Client Name _____ Date of Birth _____

Account # _____

Please complete entire form in **black** ink ONLY

CLIENT INFORMATION

Client Name: _____ (Last) _____ (First) _____ (M.I.)

Previous Name: _____ (Last) _____ (First) _____ (M.I.)

Mailing Address: _____ **City:** _____ **Zip Code:** _____

Residence Address: _____ **City:** _____ **Zip Code:** _____

Email: _____

Phone Number

Home #: _____
☐ check if okay to leave message
☐ check if okay to identify ourselves
☐ check if primary contact #

Work #: _____
☐ check if okay to leave message
☐ check if okay to identify ourselves
☐ check if primary contact #

Cell #: _____
☐ check if okay to leave message
☐ check if okay to identify ourselves
☐ check if primary contact #

Date of Birth: _____ **Gender:** ☐ Male ☐ Female ☐ TG-Male* ☐ TG-Female** ☐ Declined

*Female to Male **Male to Female

Race (Select one only):

Native Hawaiian ☐ Yes ☐ No
If yes ☐ more than 50% ☐ less than 50%

☐ American Indian Tribe _____

☐ Alaska Native Tribe _____

☐ White ☐ Pacific Islander
☐ Asian ☐ Black/African American
☐ Unknown/Refused ☐ More than one race

Ethnicity (Select one only): ☐ Hispanic / Latino ☐ Not Hispanic / Not Latino ☐ Unknown/Refused

Primary Language: ☐ English ☐ Hawaiian ☐ Other (please list): _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Widower ☐ Legally Separated ☐ Partner

RESPONSIBLE PARTY INFORMATION

Relationship to Client ☐ Self* (If Self, please skip to Employer) ☐ Spouse ☐ Parent ☐ Guardian

Responsible Party Name _____ (Last) _____ (First) _____ (M.I.)

Mailing Address: _____ **City:** _____ **Zip Code:** _____

Residence Address: _____ **City:** _____ **Zip Code:** _____

Home #: _____ **Work #:** _____ **Cell #:** _____

Date of Birth: _____ **Gender:** ☐ Male ☐ Female ☐ TG-Male* ☐ TG-Female** ☐ Declined

*Female to Male **Male to Female

Employer Name*: _____ **Phone #:** _____

Address: _____ **City:** _____ **Zip Code:** _____

Family Size: _____ **Family Income** _____$ ☐ Monthly ☐ Annual

Income Source:
☐ None ☐ Spouse ☐ DSSH – TANF ☐ Soc. Security Benefits ☐ Other: _____
☐ Self ☐ Partner ☐ Retirement ☐ SSI _____
☐ Family ☐ Unemployment ☐ SSDI _____

Employed: ☐ Part time ☐ Full time ☐ Student ☐ Retired ☐ Self-employed ☐ Unemployed ☐ Other: _____

Living Arrangement: ☐ Own Home ☐ Rent Home ☐ Living with family ☐ Homeless ☐ Other _____

Homeless:
☐ Homeless shelter ☐ On the Street ☐ Other _____
☐ Not Homeless ☐ Doubling Up ☐ Transitional

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INSURANCE INFORMATION
COPY OF ALL INSURANCE CARDS REQUIRED

MEDICAL

☐ None ☐ Refused

Medical Insurance: _____ **Member ID#:** _____ **Group #:** _____

Policy Holder: _____ _____ _____
Last First M.I.

Address: _____ **City:** _____ **Zip Code:** _____

Date of Birth: _____

DENTAL

☐ None ☐ Refused

Dental Insurance: _____ **Member ID#:** _____ **Group #:** _____

Policy Holder: _____ _____ _____
Last First M.I.

Address: _____ **City:** _____ **Zip Code:** _____

Date of Birth: _____

PROVIDER INFORMATION

Doctor Name: _____ Phone #: _____

Doctor Address: _____ Fax #: _____

Dentist Name: _____ Phone #: _____

Dentist Address: _____ Fax #: _____

ADDITIONAL INFORMATION

Emergency Contact Person: **Relationship:** **Emergency Contact #:**
(If possible someone outside your home we may talk to about your health)

_____ _____ _____

Who may we talk to about your health? **Relationship:** **Contact #:** **Good Until** (date)

_____ _____ _____ _____

Veteran Status:

Are you now serving in the U.S. Military/Coast Guard? ☐ Yes ☐ No

Have you ever served in the active U.S. Military/Coast Guard? ☐ Yes ☐ No

Referred By:

☐ Self ☐ Family ☐ Friend ☐ Doctor ☐ Agency: _____
☐ Not Applicable ☐ Other: _____

Health Care Utilization:

What types of health care do you use when you are sick/ill? ☐ Doctor ☐ Medical clinic ☐ Lomilomi
☐ Alternative Therapy (e.g., aroma, herbal, etc) ☐ None ☐ Other

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KE OLA MAMO

Authorization and Release:

I consent to the release of any information necessary to secure payment from the named insurance company. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I understand I am responsible for all charges incurred by me and my dependents to the extent not covered and promptly paid by insurance coverage. I understand that payments are non-refundable, unless payment was erroneously requested by Ke Ola Mamo and reimbursement is required by law. _____ (initials)

I authorize and consent to any diagnostic and/or medical treatment under the supervision of the attending physician and/or dentist for which my dependent or I have sought care. _____ (initials)

I give Ke Ola Mamo permission to verify the financial and insurance information provided by me to determine eligibility for Ke Ola Mamo services. I understand it is my responsibility to keep Ke Ola Mamo informed of any changes in my families' income and insurance status. _____ (initials)

The information provided above is accurate and complete to the best of my knowledge and is only to be used for Ke Ola Mamo's health care operations, statistical purposes, my treatment, billing, processing of insurance claims, and/or qualification for services to which I may be eligible. _____ (initials)

I have received a copy of or have reviewed the following Ke Ola Mamo policies:

☐ Ke Ola Mamo Notice of Privacy Practice Statement _____ (initials)

☐ Patient Rights and Responsibilities _____ (initials)

☐ Appointment Policy _____ (initials)

☐ Prescription Policy _____ (initials)

Client / Guardian Print Name	Client/Guardian Signature	Date
Received By Print Name	Received By Signature	Date
Data – Entered By:	Staff Signature	Date
Chart Reviewed By:	Reviewer's Signature, title	Date

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Client Name _____ Date of Birth _____

Account # _____ Chart # _____

Client Information

Client Statement

I participated in the development of a plan of action plan (care plan) with a Ke Ola Mamo employee and agree to work with the staff of Ke Ola Mamo to attain the goals we established. I am participating in Ke Ola Mamo's programs voluntarily and I assume any risks involved.

Client Waiver

I am voluntarily participating in ☐ Ho`oikaika-Group (Fitness Program – Group) ☐ Ho`oikaika-Personal Training ☐ Transportation ☐ Lomilomi (massage) Services ☐ Other: _____ _____ (hereinafter referred to as "The Program") coordinated / sponsored by Ke Ola Mamo, Native Hawaiian Health Care System of O`ahu. The Program activity is scheduled to take place on _____ at _____.

I understand and agree that by signing below I will waive any and all claims for personal injury and/or property damage that I may have against Ke Ola Mamo, now or in the future, which claims arise from or are related to any services or activities of The Program, and agree to hold Ke Ola Mamo harmless of such claims, even if the claims arise as a result of the negligence of Ke Ola Mamo and/or its employees, except to the extent that such waiver is in violation of Hawaii law. Furthermore, I agree to waive, defend and indemnify Ke Ola Mamo from any such claims brought by my heirs, executors, administrators, assigns, and other relation, which claims relate to the services provided to me pursuant to The Program.

I have read this agreement and understand it or have had it explained to me, and by signing below, I signify my acceptance of and agreement to its terms.

Client / Guardian Print Name	Client/Guardian Signature	Date
Witness Print Name	Witness Signature	Date