SCOTT T. KAWAMOTO, M.D., LLC ▪ RHEUMATOLOGY

Queen's Physicians Office Building III ▪ 550 S Beretania St ▪ Suite 514 ▪ Honolulu, HI 96813 ▪ Ph: [808] 523-2911 ▪ Fax: [808] 523-2912

NEW PATIENT REGISTRATION FORM

Please Print TODAY'S DATE: _____

PATIENT INFORMATION

Full Legal Name: (Last) (First) (Middle)				Nickname or Alias	
Date of Birth	Sex	Soc Sec # (optional)	Marital Status	Race ☐ Refuse to report	Preferred Language
Home Phone	Work Phone	Street Address: (not a PO address)		Mailing Address:	
Cell Phone	Pager				
Email		City, State, Zip:		City, State, Zip:	
Employer Name		Occupation			
Employer Address (Number) (Street) (Apt. #) (City) (State) (Zip Code)					

INSURANCE INFORMATION

1. Primary Insurance Company Name	Policy #	Group No.
Subscriber Name / Relationship	Soc Sec #	Date of Birth
2. Secondary Insurance Company Name	Policy #	Group No.
Subscriber Name / Relationship	Soc Sec #	Date of Birth
3. Other Insurance Information	Policy #	Group No.

SPOUSE'S INFORMATION

Full Legal Name: (Last) (First) (Middle)			Phone
Street Address (If Different From Above): (Number) (Street) (Apt. #) (City) (State) (Zip Code)			
Employer Name	Employer Address:		Work Phone

GUARANTOR or RESPONSIBLE PARTY *(if other than patient)*

Full Legal Name (Last) (First) (Middle)			Phone
Address (If Different From Above): (Number) (Street) (Apt. #) (City) (State) (Zip Code)			
Employer Name	Employer Address		Alternate Phone

EMERGENCY INFORMATION

Person to Notify in Case of Emergency (Last) (First) (Middle)						Relationship
Address: (Number)	(Street)	(Apt. #)	(City)	(State)	(Zip Code)	Home or Cell Phone

PROOF OF INSURANCE: We must obtain a copy of your current photo ID and valid insurance card(s) to provide proof of insurance.
COVERAGE CHANGES: If the above information changes, please notify us as soon as possible so we can make the appropriate changes to help you receive your maximum benefits.

(continued on reverse side)

CONSENT FOR TREATMENT

CONSENT TO TREATMENT

I authorize and consent to medical care and treatment by SCOTT T. KAWAMOTO, MD (my "Physician") (including diagnostic tests and procedures) which my treating physicians and medical providers find to be necessary and which is given or performed at their direction. I understand that any requests or restrictions related to my treatment must be discussed with my Physician.

NOTICE OF PRIVACY PRACTICE

My signature below will confirm that I have been given a copy of Notice of Privacy Practices of SCOTT T. KAWAMOTO, MD, LLC as required by the privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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 SCOTT T. KAWAMOTO, MD, LLC toward payment of my bill and direct my insurance carrier to pay these benefits to SCOTT T. KAWAMOTO, MD,LLC. My Physician will bill my insurance carrier if I provide the appropriate information in a timely fashion.

***Co-Payments and Deductibles**:* All co-payments and deductibles must be paid at the time of service. This arrangement is part of our contract with your insurance company. If you are unable to pay at the time of service, please inform our office staff as a payment plan may be arranged.

Late Payment Charge and Collection: I understand for all accounts not paid in full within 90 days (or longer if required by law), a late payment charge may be assessed and my account may be referred 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 SCOTT T. KAWAMOTO, MD, LLC of authorized benefits for all services furnished me by my Physician.

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 SCOTT T. KAWAMOTO, MD, LLC. 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 SCOTT T. KAWAMOTO, MD, LLC on my behalf.

NO SHOW POLICY: Physicians often experience a high number of no-show and cancelled appointments without advanced notice. In fairness to other patients we would like to have the opportunity to fill these appointment slots. It is therefore our policy to charge $50 if you do not show up for an appointment or cancel an appointment without giving us 24 hours (1 day) advanced notice. Initials:_____

THIRD PARTY INSURANCE: This practice does not participate with Workers' Compensation or No-Fault Insurance programs. By signing below, I attest that the reason I have made an appointment for medical care with SCOTT T. KAWAMOTO, MD, LLC is not related to a work injury or an accident related injury, motor vehicle or otherwise, and that I will not convert coverage in the future to Workers' Compensation or No-Fault Insurance. In the event that coverage is converted, I understand that I may be personally responsible for the balance in full.

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 care operations, within the limits of the law. I further understand that certain specific categories of my health information require my 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 my 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.

X _____

PRINT NAME OF PATIENT

X _____ Date: _____ Time: _____ am/pm

SIGNATURE OF PATIENT

X _____ Date: _____ Time: _____ am/pm

SIGNATURE OF PATIENT'S REPRESENTATIVE

X _____

RELATIONSHIP TO PATIENT