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NAME:
DOB:
DOS:

KALOKO
PAIN CENTER

CONFIDENTIAL PATIENT INFORMATION

PATIENT INFORMATION (please print):

Patient Name: _____

Mailing Address: _____

Date of Birth: _____ Social Security #: _____

Male □ Female □ Single □ Married □ Other □ E-Mail Address: _____

Emergency Contact (Name and Phone) _____

Primary Phone #: _____Okay to leave message: Yes or No

Secondary Phone #: _____Okay to leave message: Yes or No

Employer: _____ Work Phone #: _____

Primary Care Doctor: _____ Referred By: _____

INSURANCE INFORMATION (please print):

Insurance Company: _____ Subscriber's Name: _____

Subscriber's DOB: _____ Policy #: _____

Subscriber's Sex: Male □ Female □ Relationship to Patient: _____

Insurance Company: _____ Subscriber's Name: _____

Subscriber's DOB: _____ Policy #: _____

Subscriber's Sex: Male □ Female □ Relationship to Patient: _____

Worker's Comp Company: _____

Adjuster name & phone #: _____

Claim #: _____ DOI: _____ Employer: _____

RESPONSIBLE PARTY INFORMATION IF OTHER THAN PATIENT (please print):

Name: _____ Phone #: _____

Address: _____ City, State, Zip: _____

I hereby authorize my physician to furnish information to insurance carriers or government agencies concerning my illness and treatments and I hereby assign to them all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amounts not covered by insurance. There will be a $15.00 charge for all returned checks. A copy of this signature is as valid as the original.
If I am covered by Medicare, I authorize any holder of medical information about me to release to the Health Care Financing Administrator and its agents any information needed to determine these benefits payable for related services.

Signature of Patient/Legal Guardian: _____Date: _____

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NAME:
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DOS:

KALOKO
PAIN CENTER

75-184 Hualalai Rd., Suite 302
Kailua Kona, HI 96740
Phone: 808-329-0111
Fax: 808-365-5811

NOTICE OF PRIVACY POLICIES

It is the policy of our providers and staff to preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our providers and staff have the necessary medical and PHI to provide the highest quality of medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our providers and staff for the purposes of treatment, payment and healthcare operations (TPO). To that end, our providers and staff will:

- Adhere to the standards set forth in this Notice of Privacy Practices
- Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our providers and staff will not disclose PHI for use outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- Use and disclose PHI to remind patients of their appointments unless they instruct us not to.
- Recognize that PHI collected about patients must be accurate, timely, complete and available when needed. Our providers and staff will:
    - Implement reasonable measure to protect the integrity of all PHI maintained about patients
- Recognize that patients have a right to privacy. Our providers and staff respect the patient's individual dignity at all times. Our providers and staff will respect the patient's privacy to the extent consistent with providing the highest quality of medical care possible and with the efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our providers and staff will:
    - Treat all PHI data as confidential in accordance with professional ethics, accreditation standards and legal requirements.
    - Not disclose PHI data unless the patient (or his/her authorized representative) has properly authorized the release or law otherwise authorizes the release. Recognize that, although our providers "own" the medical record, the patient has the right to inspect and obtain a copy of his/her PHI. In addition, the patient has the right to request an amendment to his/her medical record if she/he believes his/her information is inaccurate or incomplete.
    - Permit patients access to their medical records when their written request are approved. If we deny their request, then we must inform the patient that they may request a review of our denial. In such case, we will have an on-site healthcare professional review the patient's appeal.
    - Provide patients with an opportunity to request the correct of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- Our providers and staff will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIPAA rules. We will provide this list to patients upon request, so long as their request is in writing.
- Our providers and staff will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our providers.
- Our providers and staff must adhere to this policy. Our providers will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our provider's rules and regulations.
- Our providers may change this privacy policy in the future. Any changes will be effective upon the release of a revised policy and will be made available to patients upon request.

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RECEIPT OF NOTICE OF PRIVACY POLICIES

I, _____, have read, understand, and have been given a copy of the Privacy Policies
PRINT PATIENT NAME

of the KALOKO PAIN CENTER.

FINANCIAL AGREEMENT

I understand that I am financially responsible for all charges incurred for services rendered at KALOKO PAIN CENTER, LLC whether or not paid by my insurance carrier or payor.

I understand that I am financially responsible, if I have not met my insurance deductible and/or if I have a copayment associated with my treatment(s).

If I cannot make my scheduled office appointment, I understand that I must contact Kaloko Pain Center at least 24 hours prior to my appointment to cancel or reschedule.

DISPUTE RESOLUTION PROCEDURE

In the case of a dispute or if each feels that he or she will benefit from a dispute resolution procedure as set forth in this agreement, each will attempt to resolve the dispute through amicable discussions and/or written correspondence, in a good faith attempt to understand the other's position and to resolve the matter as expeditiously as possible.
Should such negotiations fail to produce a mutually acceptable resolution of the dispute, the parties may mutually agree to submit the dispute to mediation, at any time, for further discussion and negotiation
If the dispute cannot to resolved by mediation, the parties agree that any monetary claim asserted by the patient, patient's heirs, or personal representatives, on account of bodily injury, mental disturbance or death, shall be submitted to mandatory binding arbitration in Honolulu, Hawaii, in accordance with Chapter 658A, Hawaii Revised Statutes, as revised. Such arbitration shall be conducted before a single arbitrator under the auspices of Dispute Resolution Prevention & Resolution, Inc., including its procedural rules. The arbitrator shall be appointed using the following method. Each party will submit a list of five arbitrators to the other party. Each side may strike names on the list it deems unacceptable. If only one common name remains on the lists of all parties, that individual will be the arbitrator. If more than one common name remains on the list of all parties, the parties will strike names alternately until only one remains. If no common name remains on the lists of all parties, the parties will submit an additional list and the above procedure will be repeated until an arbitrator is selected by mutual agreement. If the parties are unable to reach an agreement on an arbitrator, then either party may make application to the Circuit Court for the naming of an arbitrator, as set forth in Chapter 658A-11, Hawaii Revised Statutes. The decision of the arbitrator shall be final and binding on the parties. The arbitrator shall have the discretion to order that the costs of arbitration, including the arbitrator's fees, other costs, and reasonable attorneys' fees of the prevailing party, shall be borne by the non-prevailing party.
The arbitration will be conducted in private and will not be open to the public or the media. The testimony and other evidence presented, and the results of the arbitration are confidential and may not be disclosed, made public or reported to any person or entity, without the written consent of all parties.

_____ _____
AUTHORIZED SIGNATURE OF SUBSCRIBER DATE

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NAME:
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CONTROLLED SUBSTANCES AGREEMENT
KALOKO PAIN CENTER

The medications that are being prescribed for you can be dangerous. It is important for you to understand the rules for taking these medications and to adhere to the prescribed dose for your safety. Medications are prescribed on a trial basis only.

- ☐ The risks, side effects and benefits of the medications have been explained to me.
- ☐ The medications may need to be adjusted if my activity level and general function change.
- ☐ I agree to participate in other treatment recommendations such as physical therapy. Pain medicine is NOT my only treatment option.
- ☐ I agree to take my medication ONLY as prescribed.
- ☐ I will keep my medication in a safe place and away from children.
- ☐ I will only use _____ pharmacy. _____ location.
- ☐ I will inform my other health care providers that I am taking controlled medicines, and will NOT get medicines from another provider or Emergency room.
- ☐ I will inform my provider if I have received controlled medicine from another source including Emergency Room.
- ☐ I will not miss my follow up appointments. Refills CANNOT be handled over the phone.
- ☐ I will not ask for early refills if I run out of medication, or if medication is lost or stolen.
- ☐ Maui Pain Clinic or Kaloko Pain Center will NOT provide another prescription for lost or stolen medication.
- ☐ I will not abuse alcohol, use illegal drugs or other substances not prescribed by this provider.
- ☐ I will not sell, trade or share my medicines with anyone.
- ☐ I will allow my urine to be collected at any time.
- ☐ I agree to bring my medication in if asked to do so.
- ☐ I understand if there is reason to believe I have engaged in illegal activity, my provider may notify the proper authorities.
- ☐ I will not treat any staff members unprofessionally.
- ☐ I agree that my provider can discuss my care and this agreement with other providers or pharmacists.

I understand that immediate termination from Maui Pain Clinic or Kaloko Pain Center will be invoked if conditions are not followed. I will ask questions if I do not understand something regarding medication use. I will exercise caution and common sense at all times.

Patient_____ Date _____

APRN/Physician_____Date_____

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Opioid Risk Tool (ORT)

Are there any family members that have substance abuse in the following areas?

Alcohol abuse in **female** family member	Yes (1)	No (0)
Alcohol abuse in **male** family member	Yes (3)	No (0)
Illegal drug abuse in **female** family member	Yes (2)	No (0)
Illegal drug abuse in **male** family member	Yes (3)	No (0)
RX drug abuse in **female** family member	Yes (4)	No (0)
RX drug abuse in **male** family member	Yes (4)	No (0)

If you are FEMALE, please complete the following:

I have a personal history of alcohol abuse	Yes (3)	No (0)
I have a personal history of illegal drug abuse	Yes (4)	No (0)
I have a personal history of RX drug abuse	Yes (5)	No (0)
I am in between the ages of 16 and 45	Yes (1)	No (0)
I have a personal history of preadolescent sexual abuse	Yes (3)	No (0)
I have/am ADD, OCD, Bipolar, Schizophrenia	Yes (2)	No (0)
I have or have had depression	Yes (1)	No (0)

If you are MALE, please complete the following:

I have a personal history of alcohol abuse	Yes (3)	No (0)
I have a personal history of illegal drug abuse	Yes (4)	No (0)
I have a personal history of RX drug abuse	Yes (5)	No (0)
I am in between the ages of 16 and 45	Yes (1)	No (0)
I have a personal history of preadolescent sexual abuse	Yes (0)	No (0)
I have/am ADD, OCD, Bipolar, Schizophrenia	Yes (2)	No (0)
I have depression	Yes (1)	No (0)