PATIENT INFORMATION (please print clearly) DATE: Change Notice ☐

NAME: Last	First	Middle Initial	Nickname
Marital Status ☐ Single ☐ Married ☐ Other	Gender (circle) M F	SSN	Birth Date
Billing Address		Home Phone	Cell Phone
City/State/Zip		E-Mail	
Residential Address		Ethnicity	
City/State/Zip		Preferred Language	

PATIENT EMPLOYMENT INFORMATION Change Notice ☐

Employer	Employment Status ☐ Employed ☐ Student (circle: Full or Part) ☐ Unemployed ☐ Retired
Work Address	Occupation
City/State/Zip	Work Phone

INSURANCE Change Notice ☐

(1) PRIMARY Insurance	Member #	Group #	Plan #
Subscriber's Name	Subscriber's Birth Date	Relationship to Patient	
(2) SECONDARY Insurance	Member #	Group #	Plan #
Subscriber's Name	Subscriber's Birth Date	Relationship to Patient	
(3) TERTIARY Insurance	Member #	Group #	Plan #
Subscriber's Name	Subscriber's Birth Date	Relationship to Patient	

Complete GUARANTOR INFORMATION (financially responsible party) if other than SELF. Change Notice ☐

Name	Relationship to Patient	Phone
Address	City/State/Zip	

EMERGENCY CONTACT Change Notice ☐

Name			Relationship to Patient
Home Phone	Work Phone	Cell Phone	E-Mail

PLEASE LIST THE NAMES OF THOSE WHOM WE MAY DISCLOSE YOUR MEDICAL INFORMATION TO SHOULD THEY REQUEST ON YOUR BEHALF. FOR EXAMPLE: SPOUSE, PARENT, CHILDREN, ETC.

AUTHORIZATION, CONSENT, & NOTICE OF PRIVACY PRACTICES

AUTHORIZATION FOR TREATMENT: I hereby authorize and consent Honolulu Primary Care Associates, LLC and/or its representatives to provide diagnostic and/or medical treatment to me.

RELEASE OF INFORMATION: I authorize the release of any medical information relating to services rendered to me, or to the person for whom I am parent or legal guardian, for the purpose of processing my health insurance claim(s).

ASSIGNMENT OF BENEFITS: I authorize direct payment by my health insurance to Honolulu Primary Care Associates, LLC and understand that I am responsible for all payment of services to include deductibles, co-payments, and/or non-covered benefits. If Honolulu Primary Care Associates, LLC is unable to obtain a settlement with my insurance carrier(s), I acknowledge that they reserve the right to bill me directly for all services rendered. All co-payments are due at the time of services.

LATE PAYMENT CHARGES: I acknowledge that all charges are due and payable immediately upon receipt of the statement. After deducting payments and credits, a late payment fee of 1% per month will be charged on all account balances 60 or more days past the visit date.

ACCEPTANCE: I acknowledge that I have read and understand the foregoing information, and as a patient, or as parent or legal guardian, is the responsible party for the patient, and accept its terms.

NOTICE OF PRIVACY PRACTICES: I have reviewed and was offered a copy of the Notice of Privacy Practices.

Patient Signature	Date

Relationship to Patient (if patient is a minor or requires guardianship)