Hui Mālama Ola Nā ʻŌiwi

Native Hawaiian Health Care System

Aloha and welcome to the Hui Mālama Ola Nā ʻŌiwi Family Medicine Clinic. Mahalo nui for your interest in becoming one of our patients. Hui Mālama Ola Nā ʻŌiwi is a 501(c)(3) nonprofit organization dedicated to improving the health & wellness of Hawaiʻi island. Services are offered island-wide and open to everyone in the community.

We take a comprehensive approach to help you and your `ohana (family) reach your wellness goals and stay as healthy as possible. Our care team includes kauka (doctors), a nurse practitioner, a licensed clinical social worker, registered dietitians, and certified medical assistants. In the near future, we anticipate having students in medicine, nursing, clinical pharmacy, and behavioral health sciences. All patients of our clinic should expect to be seen by various team members including students, at times. We appreciate your patience as we re-establish our clinic in Hilo on Hawaiʻi Island and would like to assure you that you will receive comprehensive and detailed care.

As the Native Hawaiian Health Care System serving Hawaiʻi Island, we are committed to providing the best care possible to our community. So that we can assess your health care needs, please complete the patient registration documents, including your health history. We will review your application and if you are accepted as a patient, we will request your medical records from your previous provider(s) within the last seven years and contact you to schedule your initial appointment. We will try our best to communicate any delays, should there be any concerns or issues.

Again, mahalo nui loa for your interest in becoming a patient with Hui Mālama Ola Nā ʻŌiwi Family Medicine Clinic. We believe you will enjoy being a patient and look forward to being your Medical Care team.

PRIMARY CARE PROVIDERS
John Engle, MD
Gaku Yamaguchi, MD
Peter Donnelly, MD
Lauren Butcher, APRN

BEHAVIORAL HEALTH
Byers Na`ope, LCSW

NUTRITION AND HEALTH EDUCATION
Joanne Chow, RDN

Hui Mālama Ola Nā ʻŌiwi Family Medicine Clinic
82 Puʻuhonu Place Suite 209, Hilo, Hawaiʻi 96720
Phone: (808) 796-3125
Fax: (866) 372-2766
www.HMONO.org

HUI MĀLAMA OLA NĀ ʻŌIWI

Native Hawaiian Health Care System
Health & Program Services

CLIENT/PATIENT REGISTRATION FORM

Services interested in: ☐ **Medical/Behavioral Health Services** ☐ **Traditional Hawaiian Health** ☐ **Exercise** ☐ **Nutrition** ☐ **Diabetes Program** ☐ **Specialty Transportation** ☐ **Healthy Hapai Program** ☐ **Hypertension** ☐ **Cancer Support Group**

If interested in Medical/Behavioral Health Services fill out entire form. ***All other services fill out only the shaded areas***

Patient Legal Last Name	Suffix	Patient First Name &Middle Initial	Nickname
Residence Address		City/Town	Zip code
Mailing/Other Address		City/Town	Zip Code

Home Phone #	Cell Phone #	Work Phone #	Email
Date of Birth:		Age:	Social Security Number
Name of Primary Care Provider:		Were you referred? ☐ Yes ☐ No Who referred you: _____	

Marital Status
◯ Single ◯ Partner
◯ Married ◯ Divorced
◯ Legally Separated ◯ Widowed

Gender: ◯ Male ◯ Female ◯ Transgender Male/Female ◯ Transgender Female/Male ◯ Other ◯ Choose not to disclose

Sexual Orientation: ◯ Straight ◯ Gay/Lesbian ◯ Bisexual ◯ Something else ◯ Don't Know ◯ Choose not to disclose

RESPONSIBLE PARTY INFORMATION

RELATIONSHIP TO PATIENT: ◯ **SELF** ◯ **SPOUSE** ◯ **PARENT** ◯ **GUARDIAN**

Name:	Relationship to Patient	Contact #
Mailing address:	City/State:	Zip code:

PRIMARY INSURANCE INFORMATION: ☐ None ☐ Medical

Primary Insurance:	Membership ID#	Group#
Subscriber Name:	Date of Birth:	Plan#

SECONDARY INSURANCE INFORMATION: ☐ None ☐ Medical

Secondary Insurance	Membership ID#	Group#
Subscriber Name:	Date of Birth	Plan#

I authorize this office to release to the named insurance company any information necessary to secure insurance payment. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I understand I am responsible for all charges regardless of insurance coverage.

Initial Here: _____

Are you pregnant? ◯ **Yes** ◯ **No** ***If yes,** have you received prenatal care in your first trimester of pregnancy? ◯ **Yes** ◯ **No**	**Are you a parent of a child under 3?** ◯ **Yes** ◯ **No** ***If yes,** has your child received the 24-25 recommended immunization ◯ Yes ◯ No ◯ I don't know	**Are you diagnosed with any of the following?** ☐ **Diabetes** ☐ **Hypertension** ☐ **Cancer**

HOUSEHOLD INFORMATION

Income $ _____ ◯ Monthly ◯ Annual Family Size _____ ◯ I don't want to disclose income information

Homeless

- ◯ Not Homeless
- ◯ Homeless Shelter
- ◯ Transitional
- ◯ Doubling Up
- ◯ Street
- ◯ Other _____
- ◯ Yes, but unknown

If homeless, for how long: _____

Primary Language

- ◯ English
- ◯ Hawaiian
- ◯ Other_____

Are you Hawaiian? ◯ Yes ◯ No

Ethnicity

- ◯ Hispanic or Latino
- ◯ Non-Hispanic or Latino
- ◯ Undisclosed

Race (check all that apply)

- ☐ Native Hawaiian
- ☐ Asian
- ☐ White
- ☐ Other Pacific Islander
- ☐ Undisclosed
- ☐ Black
- ☐ American Indian or Alaska Native

EMPLOYED

◯ Full Time ◯ Part-Time ◯ Unemployed ◯ Self Employed ◯ Retired ◯ Student ◯ N/A ◯ Other _____

EMPLOYER NAME	**EMPLOYER PHONE#**

AGRICULTURALWORKER OR DEPENDANT: ◯ Yes ◯ No

VETERAN: ◯ Veteran ◯ Veteran Family Member ◯ N/A

EMERGENCY CONTACT INFORMATION

List Person we may contact in case of emergency

Name: _____ Relationship: _____

Phone: _____

☐ Check if OK to leave message at your home phone	☐ Check if OK to leave message on cell phone	☐ Check if OK to leave message at work phone	☐ Check if OK to say we are from Hui Mālama Ola Nā ʻŌiwi when we write or call?

How did you hear about us?

☐ **Hui Mālama Staff** ☐ **Family/Friend** ☐ **Physician Referral** ☐ **Website** ☐ **Community Event**
☐ **Flyer** ☐ **Newsletter** ☐ **Newspaper** ☐ **Social Media** ☐ **Search Engine** ☐ **Other_____**

HUI MĀLAMA OLA NĀ ʻŌIWI-Authorization and Release Form

I hereby authorize the release of information which has been obtained about me. I understand that this information will be used for statistical purposes and/or to help me receive the benefits to which I may be entitled. My name will not be used, only a code number. Initial Here: _____

I authorize and consent to any diagnostic and/or medical treatment under the instruction of the attending physician and/or medical professional for which my dependent or I have sought care. Initial Here: _____

I give Hui Mālama Ola Nā ʻŌiwi permission to verify the financial and insurance information provided by me to determine eligibility for Hui Mālama Ola Nā ʻŌiwi health services. I understand it is my responsibility to keep Hui Mālama Ola Nā ʻŌiwi informed of any changes in my family's income and insurance status. Initial Here: _____

All information on this form is true and accurate to the best of my knowledge:

_____ _____

Signature (Patient Party/Legal Guardian) **Date**

_____ _____

Please Print your Name Here **Witness**

FORM: Patient Client Registration
Effective: 1/2019

Staff Signature: _____ Date: _____

Hui Mālama Ola Nā ʻŌiwi

Native Hawaiian Health Care System

REFERRAL FORM

Please fax completed form to 1-866-372-2766

Last Name:	First Name:	Middle Initial(s):

Date of Birth:	Age:	Sex: ◯Male ◯Female ◯Other	Phone:

Address:

Mailing Address (If different than above):

Health Insurance Provider:	Member ID:

Services Being Referred For:

Family Medicine Clinic
- ❑ Primary Care Provider
- ❑ Behavioral Health
- ❑ Nutrition Education (Individual)
- ❑ Diabetes Education (Individual)

Traditional Hawaiian Healing
- ❑ Grow Your Own Laʻau
- ❑ Mala 101
- ❑ Hoʻoponopono
  - ❑ Group ❑ Individual
- ❑ Laʻau Lapaʻau
- ❑ Lomilomi
- ❑ Healthy Hapai Prenatal Program

Health Enhancement Classes
- ❑ Basic Nutrition
- ❑ Chronic Kidney Disease
- ❑ Diabetes Education
- ❑ Exercise & Fitness
- ❑ Hypertension
- ❑ Mindful Eating Lab

- ❑ Specialty Transportation
- ❑ Support Group
  - ❑ Cancer
  - ❑ Diabetes (Adult)
  - ❑ Diabetes (Youth)
  - ❑ Wellness
- ❑ Health Resource Services

Referring Physician

Physician/Clinic: _____ Phone: _____

Address: _____ Diagnosis/ICD-10: _____

Reason For Referral:

I hereby certify that I am managing this client's health condition and that the above prescribed services are a necessary part of management.

Physician Signature:_____ **Print Name:**_____ **Date:**_____

All of the above has been discussed and reviewed with me and I agree to be referred to the service(s) as recommended.

Client Signature: _____ **Date**: _____

Staff Signature:_____ **Print Name:**_____ **Date:**_____

Administration: 1438 Kīlauea Avenue, Hilo, HI 96720 | (808) 969-9220
Family Medicine Clinic: 82 Puʻuhonu Place, Suite 209, Hilo, HI 96720 | (808) 796-3125
Website: www.hmono.org

HEALTH HISTORY

CONFIDENTIAL

Patient Name_____Today's Date_____

Age_____Birthdate_____Date of last physical examination_____

What is your reason for visit? _____PCP_____

CONDITIONS Check (✓) symptoms you have or have had in the past.

☐ AIDS	☐ Chemical Dependence	☐ High Cholesterol	☐ Prostate Problem
☐ Alcoholism	☐ Chicken Pox	☐ HIV Positive	☐ Psychiatric Care
☐ Anemia	☐ Diabetes	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anorexia	☐ Emphysema	☐ Liver Disease	☐ Scarlet Fever
☐ Appendicitis	☐ Epilepsy	☐ Measles	☐ Stroke
☐ Arthritis	☐ Glaucoma	☐ Migraine Headaches	☐ Suicide Attempt
☐ Asthma	☐ Goiter	☐ Miscarriage	☐ Thyroid Problems
☐ Bleeding Disorders	☐ Gonorrhea	☐ Mononucleosis	☐ Tonsillitis
☐ Breast Lump	☐ Gout	☐ Multiple Sclerosis	☐ Tuberculosis
☐ Bronchitis	☐ Heart Disease	☐ Mumps	☐ Typhoid Fever
☐ Bulimia	☐ Hepatitis	☐ Pacemaker	☐ Ulcers
☐ Cancer	☐ Hernia	☐ Pneumonia	☐ Vaginal Infections
☐ Cataracts	☐ Herpes	☐ Polio	☐ Venereal Disease

HEALTH MAINTENANCE

MEN only

- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicle
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Colonoscopy
- ☐ Other_____

WOMEN only

- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Colonoscopy
- ☐ Vaginal discharge
- ☐ Other_____

Date of last menstrual period_____

Date of last Pap Smear_____

Have you had a mammogram? _____

Are you pregnant? _____

Number of children_____

DO YOU EXERCISE? ☐ Yes ☐ No *If yes, answer the following*	**MEDICATIONS** List medications you are currently taking
List type of exercise:	
How often?	
How long?	
Other activities:	
ALLERGIES To medications or substance	
Pharmacy Name:	
Location	

All information is strictly confidential

FAMILY HISTORY Fill in health information about your immediate family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓), if your blood relatives or you have had any of the following: Disease	Relationship to you
					Arthritis, Gout	
					Asthma, Hay Fever	
					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

PAST MEDICAL HISTORY

Have you ever had a blood transfusion? ☐ Yes ☐ No

If yes, please give approximate dates.

_____

PAST SURGICAL HISTORY

YEAR	FACILITY	TYPE OF SURGERY AND OUTCOME

PREGNANCY HISTORY

# of Pregnancies	Term/ Preterm	Abortion/ Miscarriage

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

	Alcohol	
	Caffeine	
	Street Drugs	
	Tobacco	
	Vaping/E-cig	
	Other	

OCCUPATIONAL CONCERNS

Check (✓) if your work exposes you to the following:

	Stress
	Hazardous
	Heavy Lifting
	Other

Your Occupation:

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor, if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative Date

Hui Mālama Ola Nā ʻŌiwi

Native Hawaiian Health Care System

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

TO: _____

_____

_____

PATIENT NAME: _____

DATE OF BIRTH: _____

PLEASE SEND INFORMATION TO: **Hui Mālama Ola Nā ʻŌiwi-Family Medicine Clinic**
82 Puʻuhonu Place, Suite 209
Hilo, Hawaiʻi 96720 **P: (808) 796-3125** **Fax: 1-866-372-2766**

Purpose of Release:

- ☐ **Transfer of Care/Changing Primary Care Physician**
- ☐ **OTHER: (please specify)**_____

Please release the following:

- ☐ **Complete Chart/ALL Records**
- ☐ **OTHER: (please specify)**_____

Protected or Sensitive Information pertaining to*: *(please INITIAL all that apply)
By initialing, I specifically authorize release of the following protected or sensitive information:

_____HIV/AIDS
_____ALCOHOL OR DRUG USE
_____BEHAVIORAL/MENTAL HEALTH
_____OTHER
_____**ALL OF THE ABOVE**

***Term*: I understand that this authorization will remain in effect:**

- ☐ **From the date of this Authorization until the _____ day of _____, 20____.**
- ☐ **Until the Provider fulfills this request.**
- ☐ **Until the following event occurs: _____**

Redisclosure: **I understand that my health care provider cannot guarantee that the recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.**
***Refusal to sign/right to revoke*: I understand that signing this form is voluntary and that if I don't sign it will not affect the commencement, continuation or quality of my treatment at HUI MĀLAMA OLA NĀ ʻŌIWI Family Medicine clinic. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to the HUI MĀLAMA OLA NĀ ʻŌIWI Family Medicine clinic at the address listed above. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before it received my written notice of revocation.**

I hereby authorize and request the release of information on myself, or that of my minor child listed above to be released to **HUI MĀLAMA OLA NĀ ʻŌIWI**. I am aware that the records released may contain information relating to psychiatric or psychological testing, physical abuse or drug and alcohol abuse.

_____ _____

Signature of Patient, parent or legal guardian of minor **Date**

_____

If not the patient, name and relationship of person completing form (please print)

This consent shall expire on the date specifically indicated above and may be revoked by the signer at any time. Incomplete information will delay processing. Use of this information for any other than the stated purpose is prohibited. It is for the use of the designated recipient only and cannot be provided to any other agency.

Hui Mālama Ola Nā ʻŌiwi

Native Hawaiian Health Care System

PATIENT INFORMATION SHEET

APPOINTMENT POLICY

Hui Mālama Ola Nā ʻŌiwi is here to serve our community and to help meet the health care needs of our native Hawaiian people. Patients are seen by appointment only. Walk-in patients without an appointment may be seen based on medical necessity and if the clinic has availability.

If you have a scheduled appointment and need to cancel, please notify us immediately so we can offer that time/space to other patients needing to be seen. As a courtesy to all our patients, if you are 15 minutes late for your scheduled appointment, you will be asked to reschedule.

PRESCRIPTION POLICY

All prescription refills must be approved by the Physician, and require up to three working days (72 hours) to process. **PLEASE PLAN AHEAD**. For example, do not call the day before your medication runs out. Give yourself at least one week of medicine left, then call our office for a refill. Prescription refills will only be approved if the Physician feels it is safe for you to receive them; you may be required to come in before your prescription is refilled.

When calling our office for a refill, don't forget to include the name of the medication you are taking, the dosage (i.e. 50 mg), how often your take it, the name of the pharmacy you would like your medication filled at, and a current phone number in case we need to reach you regarding your medications.

Our Physicians here at Hui Mālama Ola Nā ʻŌiwi do not believe that chronic pain is best treated with narcotic pain medication. If you require long-term addictive pain medications, we will help you find an alternative, or refer you to pain management services.

I have read and understand the information said above. By signing below I agree to abide by the rules set forth on this statement.

Print Name:_____ Signature:_____

Witness:_____ Date:_____

Hui Mālama Ola Nā ʻŌiwi
Family Medical Clinic

Patient Information

Handbook

Live Longer and Feel Better, Together!

Call (808) 796-3125

Email: familymedicine@hmono.org

Hui Mālama Ola Nā ʻŌiwi Family Medicine Clinic
82 Puʻuhonu Place, Suite 209
Hilo, Hawaiʻi 96720

Hui Mālama Ola Nā ʻŌiwi

Native Hawaiian Health Care System

Our Mission: To provide health services and enhance the quality of life among our Native Hawaiian People.

Our Vision: We envision a health community, Native Hawaiians and their' Ohana, where everyone achieves their full potential-spiritually, mentally and physically.

Mission and Vision Statement:

ʻO Hui Mālama Ola Nā ʻŌiwi mākou.
We are the group that takes care of
the health of Hawaiian people.

Eia ke kuleana: Hoʻoulu ola ka lāhui Hawaiʻi.
Our Mission is to uplift the health of the Hawaiian nation.

Mālama iā Moku o Keawe,
We will take care of Hawaiʻi Island,

Mālama i nā kuaʻāina,
Country and rural areas,

Mālama i kou olakino,
Your physical, spiritual
and mental body,

Mālama i nā mea Hawaiʻi.
And Hawaiian culture and practices.

E hoʻoikaika a ola ka lāhui Hawaiʻi.
We envision a strong and healthy Hawaiian nation.

Hui Mālama Ola Nā ʻŌiwi

Native Hawaiian Health Care System

ACKNOWLEDGMENT OF RECEIPT OF

NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. I may obtain a revised copy of the Notice by calling (808) 969-9220 or on HMONO's website at www.HMONO.org or by requesting one at the HMONŌ offices.

_____ _____

(Date) (Signature*)

_____

(Print or Type Name)

*As the representative of the above individual, I acknowledge receipt of the Notice on his or her behalf.

_____ _____

(Signature) (Relationship)

_____

(Date)

Hui Mālama Ola Nā ʻŌiwi

Native Hawaiian Health Care System

HIPAA Right of Access Form for Family Member/Friend/Representative

I, _____, direct my health care and medical services providers and payers to disclose and release my protected health information described below to:

Name: _____ Relationship: _____

Address: _____ Phone: _____

Health Information to be disclosed upon the request of the person named above -- (Check either A or B):

☐ A. **Disclose** my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**

☐ B. **Disclose** my health record, as above, **BUT do not disclose** the following (check as appropriate):

- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify):

_____

_____

This authorization shall be effective until (Check one):

☐ All past, present, and future periods, OR

☐ Date or event: _____ unless revoke it. (NOTE: You may revoke this authorization in writing at any time by notifying your health care providers, preferably in writing.)

_____ _____

Name of Individual Giving this Authorization Date of Birth

_____ _____

Signature of Individual Giving this Authorization Date

Patient Rights

Patients' rights include rights described below and any other rights that may be described in the Patient Rights Handbook or otherwise protected by law:

1. Receive care regardless of race, religion, national origin, disability, sex, sexual orientation, age or source of payment for care.
2. Be seen in a private and secure area during treatment within the capacity of Hui Mālama Ola Nā ʻŌiwi Family Medical Clinic.
3. Know the name and specialty of the physician or other person responsible for your care or for coordinating your care.
4. The patient has the right to be referred to other services available upon request.
5. Be actively involved in the decisions regarding your care.
6. Refuse treatment to the extent permitted by law and be informed of the potential consequences of that refusal.
7. Refuse to participate in educational, research, or experimental treatment.
8. Be informed of your condition and the treatment(s) recommended, including information about the potential benefits, risks and alternative treatments regarding any surgery or other intrusive treatment.
9. Refuse to sign consent for HMONO/FMC until you understand what you are signing.
10. Designate a family member or representative of your choice to make informed decisions about your care, if you so choose.
11. Formulate advance directives and have them followed.
12. Protection of the confidentiality of your medical records and communications to the extent provided by law.
13. Inspect your medical records and ask for a copy of your medical records within the limits of the law (copying fees may be applicable).
14. Obtain explanations of monies owed to HMONO/ or receive an itemized bill reflecting your costs.
15. Express concerns or grievances regarding your care or treatment.

Patient Responsibilities

Patient responsibilities include the following as well as any other responsibilities set forth in the Patient Rights and Responsibilities Handbook, or as imposed by any applicable law or regulation:

1. Treat all other persons (patients, family members, vendors, staff members) at HMONO/FMC with courtesy, dignity and respect at all times.
2. For yourself, family members, friends and caregivers to be clean and sober, and not under the influence of alcohol or drugs.
3. Respect the rights and property of HMONO/FMC, its staff, vendors and other patients, and follow the rules and regulations of HMONO/FMC at all times.
4. Take an active part in developing the treatment plan for your care and cooperate with the treatment you and your provider have agreed upon.
5. Report any changes in your condition or symptoms to HMONO/FMC.
6. Notify any member of the healthcare team, if you do not understand.
7. Provide information about your care and treatment, or about any information you are provided or any papers you are requested to complete.
8. Follow up and be on time for scheduled appointments and cancel appointments before the scheduled appointment according to HMONO/FMC policies. This includes any specialty, labs, diagnostics or referral appointments made for you.
9. Provide accurate and complete information about all matters pertaining to your health, including an accurate medical history including past illnesses, medications, allergies, hospitalizations, family and social histories.
10. Provide accurate information for registration, billing, payment, informed consents and promptly notify HMONO/FMC of any changes in your address, phone number, insurance coverage and/or contact information.
11. Promptly pay any financial obligations to HMONO/FMC or make a satisfactory form of payment arrangement with HMONO/FMC.
12. Keep your personal belongings in a safe place and do not bring valuables to HMONO/FMC. Lost or stolen personal items are not the responsibility of HMONO/FMC.
13. Promptly inform a member of your health team or the clinical manager of any concerns you may have regarding your care.

HIPAA NOTICE OF PRIVACY PRACTICES
THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED BY HUI MĀLAMA OLA NĀ ʻŌIWI

If you have any questions about this notice, please contact Hui Mālama Ola Nā ʻŌiwi, attention Executive Director (808) 969-9220.

WHO WILL FOLLOW THIS NOTICE:
Hui Mālama Ola Nā ʻŌiwi (HMONO).

This notice describes our privacy practices. All these entities, sites, and locations follow the terms of this notice. In addition, these entities, sites, and locations may share health information with each other for treatment, payment, or health care operations purposes described in this notice.

OUR PLEDGE REGARDING HEALTH INFORMATION
We understand that health information about you and your health care is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care generated by this health care practice, whether made by your personal doctor or others working in this office. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private.
- Give you this notice of our legal duties and privacy practices with health information about you.
- Follow the terms of the notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU
The following categories describe different ways that we use and disclose health information. For each category of uses or disclosures we will explain what we mean and try to give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to doctors, nurses, technicians, health students, or other personnel who are consulted to take x-rays, to perform lab test, to have prescriptions filled, or for other treatment purposes; and to others involved in taking care of you. They may work at our offices, at the hospital if you are hospitalized under our supervision, or at another doctor's office, lab pharmacy, or other health care provider to whom we may refer you for example, a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. In addition, the doctor may need to tell the dietitian at the hospital if you have diabetes so that we can arrange for appropriate meals. We may also disclose health information about you

to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

For Payment: We may use and disclose health information about you so that the treatment and services you receive from us may be billed to and payment collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about your office visit so your health plan will pay us or reimburse you for the visit. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether you plan will cover the treatment.

For Health Care Operations: We may use and disclose health information about you for operations of our health care practice. These uses and disclosures are necessary to run our practice and make sure that all of our patients receive quality care. For example, we may use health information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine health information about many patients to decide what additional services we should offer, what services are not needed, whether certain new treatments are effective, or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our specific patients are.

Appointment Reminders: We may use and disclose health information to contact you as a reminder that you have an appointment. Please let us know if you do not wish to have us contact you concerning your appointment, or if you wish to have us use a different telephone number or address to contact you for this purpose.

As Required By Law: We will disclose health information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety: We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the treat.

Military and Veterans: If you are a member of the armed forces or separated/discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

Workers' Compensation: We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

Public Health Risks: We may disclose health information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify person or organization required to receive information on FDA-regulated

products;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities: We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in a response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release health information if asked to do so by a law enforcement official:

- in reporting certain injuries, as required by law, gunshot wounds, burns, injuries to perpetrators of crime;
- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person:
  - -Name and address;
  - -Date of birth or place of birth;
  - -Social Security number;
  - -Blood type or Rh factor;
  - -Type of injury;
  - -Date and time of treatment and/or death, if applicable; and
  - -A description of distinguishing physical characteristics.
- about the victim of a crime, if the victim agrees to disclosure or under certain limited circumstances, we are unable to obtain the person's agreement;
- about a death we believe may be the result of criminal conduct;
- about criminal conduct at our facility; and
- in emergency circumstances to report a crime; the location of the crime or victim; or the identity, description, or location of the person who committed the crime.

Coroners, Health Examiners and Funeral Directors: We may release health information to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities: We may release health information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Protective Services for the President and Others: We may disclose health information about you to authorized federal officials so they may provide protection to the President,

other authorized persons or foreign heads of state or conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU
You have the following rights regarding health information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy health information that may be used to make decisions about your care. Usually, this includes health and billing records. This does not include psychotherapy and substance abuse notes.

To inspect and copy health information that may be used to make decisions about you, you must submit your request in writing to Hui Mālama Ola Nā `Ōiwi, attention Executive Director. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies and services associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by our practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to Amend: If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we keep the information. To request an amendment, your request must be made in writing, submitted to Hui Mālama Ola Nā `Ōiwi, attention Executive Director. In addition, you must provide a reason that supports your request for an amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
- is not part of the health information kept by or for our practice;
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

Any amendment we make to your health information will be disclosed to those with whom we disclose information as previously specified.

Right to an Accounting of Disclosures: You have the right to request a list accounting for any disclosures of your health information we have made, except for uses and disclosures for treatment, payment, and health care operations, as previously described.

To request this list of disclosures, you must submit your request in writing to Hui Mālama Ola Nā `Ōiwi, attention Executive Director. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures in writing within 30 days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; but this date will not exceed a total of 60 days from the date you made the request.

Right to Request Restrictions: You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we restrict a specified nurse from use of your information, or that we not disclose information to your spouse about a surgery you had.

We are not required to agree to your request for restrictions if it is not feasible for us to ensure our compliance or believe it will negatively impact the care we may provide you. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request a restriction, you must make your request in writing to Hui Mālama Ola Nā `Ōiwi, attention Executive Director. In your request, you must tell us what information you want to limit and to whom you want the limits to apply; for example, use of any information by a specified nurse, or disclosure of specified surgery to your spouse.

Right to Request Confidential Communications: You have the right to request that we communicate with you about health matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail to a post office box.

To request confidential communications, you must make your request in writing to Hui Mālama Ola Nā `Ōiwi, attention Executive Director. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice: You have the right to obtain a paper copy of this notice at any time. To obtain a copy, please request it from any Hui Mālama Ola Nā `Ōiwi staff member.

You may also obtain a copy of this notice from our website, www.hmono.org. Even if you have received a notice electronically, you still retain the right to receive a paper copy upon request.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for health information we already have about you as well as any

information we receive in the future. We will post a copy of the current notice in our facility. The notice will contain on the first page, in the top right-hand corner, the effective date. In addition, each time you register for treatment or health care services, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint. You may either file a complaint with us or with the Secretary of Health and Human Services. To file a complaint with us, contact Hui Mālama Ola Nā `Ōiwi, attention Executive Director. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

ACKNOWLEDGEMENT OF RECEIPT OF THIS NOTICE

We will request that you sign a separate form or notice acknowledging you have received a copy of this notice. If you choose, or are not able to sign, a staff member will sign their name, date. This acknowledgement will be filed with your records.

Hui Mālama Ola Nā ʻŌiwi

Native Hawaiian Health Care System

Sliding Fee Discount Program

Hui Malama Ola Na `Oiwi (HMONO) accepts all Medicare and Medicaid insurance plans, as well as most major insurances. The Sliding Fee Discount is in place to meet the needs of the uninsured or underinsured, providing reduced costs on services for those who qualify. Services are offered regardless of insurance status or ability to pay.

WHAT IS THE SLIDING FEE DISCOUNT PROGRAM? A program designed to help cover your out-of-pocket expenses for services provided by HMONO.

HOW DO I PARTICIPATE? Fill out a Sliding Fee Discount Application. All patients are welcome to apply. Your discount, if any, depends on your income and family size. You can apply at any time. Our staff can help you fill out the application. If you qualify, you must reapply annually.

HOW MUCH IS THE DISCOUNT? Depending on your income and family size, this program allows patients to pay a set fee. Income categories are based on the Federal Poverty guidelines. Please see our Sliding Fee Discount Application for income and family member definitions.

Family Size	Maximum annual earnings to qualify for discount.			
1	$ 15,630	$ 21,569	$ 23,445	$ 31,260
2	$ 21,060	$ 29,063	$ 31,590	$ 42,120
3	$ 26,490	$ 36,556	$ 39,735	$ 52,980
4	$ 31,920	$ 44,050	$ 47,880	$ 63,840
5	$ 37,350	$ 51,543	$ 56,025	$ 74,700
6	$ 42,780	$ 59,036	$ 64,170	$ 85,560
7	$ 48,210	$ 66,530	$ 72,315	$ 96,420
8	$ 53,640	$ 74,023	$ 80,460	$ 107,280
Discounted Fee*	**$10**	**$20**	**$25**	**$50**

*Discounted Fees for Medical visit, Behavioral Health visit, and Traditional Healing Services

ACKNOWLEDGMENT I am aware that HMONO offers a sliding fee discount for qualified applicants. HMONO will not deny services based on a patient's ability to pay.

☐ **I would like an application to be considered for a sliding fee discount.**

☐ **I am not interested in receiving a sliding fee application at this time. I understand I may request an application at any time in the future if my circumstances change.**

_____ _____ _____

Patient Name Patient Signature Date

Hui Malama Ola Na Oiwi

Sliding Fee Scale

Calendar Year End 12/31/2022

	Level A	**Level B**	**Level C**	**Level D**	
% of Poverty Level	100%	101% - 138%	139% -150%	151% - 200%	Above 200%
Family Size	**Maximum annual earnings in each level**				
1	15,630	21,569	23,445	31,260	No Discount Given
2	21,060	29,063	31,590	42,120	No Discount Given
3	26,490	36,556	39,735	52,980	No Discount Given
4	31,920	44,050	47,880	63,840	No Discount Given
5	37,350	51,543	56,025	74,700	No Discount Given
6	42,780	59,036	64,170	85,560	No Discount Given
7	48,210	66,530	72,315	96,420	No Discount Given
8	53,640	74,023	80,460	107,280	No Discount Given

for families with more than 8 persons, add $5,080 for each person

	Level A	**Level B**	**Level C**	**Level D**	
% of Poverty Level	100%	101% - 138%	139% -150%	151% - 200%	Above 200%
Family Size	**Maximum monthly earnings in each level**				
1	1,303	1,797	1,954	2,605	No Discount Given
2	1,755	2,422	2,633	3,510	No Discount Given
3	2,208	3,046	3,311	4,415	No Discount Given
4	2,660	3,671	3,990	5,320	No Discount Given
5	3,113	4,295	4,669	6,225	No Discount Given
6	3,565	4,920	5,348	7,130	No Discount Given
7	4,018	5,544	6,026	8,035	No Discount Given
8	4,470	6,169	6,705	8,940	No Discount Given

for families with more than 8 persons, add $423 for each person

	Level A	**Level B**	**Level C**	**Level D**
Services	**Maximum amount charged per visit**			
Medical	$10	$20	$25	$50
Behavioral Health	$10	$20	$25	$50
Traditional Services	$10	$20	$25	$50

*Approved by Board of Directors 1/27/2022