KOKO CLIENT DEMOGRAPHICS FORM (Rev. 9/9/16)

Client's Name:
Last First Middle Initial

Birthday (MM/DD/YYY): ________

Gender: M F

Social Security Number:

Marital Status (circle):
Single Married Separated Divorced

Email Address:

Physical Address: Street City State Zip

Mailing Address: Street City State Zip

Home Phone: Message ok?: **Cell Phone:** Message ok?:

Ethnicity (circle): Hawaiian/Pt Hawaiian Caucasian Portuguese Hispanic Asian Other

Name of Employer:

Status (circle): Full Part

Name of Responsible Party if Not Patient:
Last First Middle Initial

Home Phone:

Cell Phone:

Mailing Address of Responsible Party:
Street City State Zip

Employer of Responsible Party:

Phone Number:

Primary Insurance:

Subscriber's Name:

Insurance #:

Date of Birth:

Secondary Insurance:

Subscriber's Name:

Insurance #:

Date of Birth:

Emergency Contact:

Phone Number:

Relationship to Client:

I understand that Kīpuka o ke Ola (KOKO) participates with certain insurance plans, and as a courtesy will only ask for an estimated co-pay for each visit. If KOKO does not participate in my plan, I will be asked to pay the full amount at the time of service. In any case, I realize and agree that I am responsible for understanding my plan, benefits, and referral requirements, and that I am responsible for all charges.

Client or Guardian Signature:

Date:

Kīpuka o ke Ola

Native Hawaiian Rural Health Clinic
Physical Address: 64-1035 Māmalahoa Hwy, Suite F, Kamuela, HI 96743
Mailing Address: PO Box 818, Kamuela, HI 96743
Office Phone: 808-885-5900 FAX: 808-885-6900

Well Baby Check: New Born Visit Questionnaire

Today's date: ________Name: ______________________________

□ Male □ Female Date of Birth: __________ Hospital Delivered at: ______________________

Interval History:

1. Number of weeks pregnant on day of birth?			
2. Were there any pregnancy, labor & delivery complication (examples: pre-eclampsia, high blood pressure, diabetes, abnormal ultrasound, emergency delivery, etc.)?	No	Yes – Please explain:	
3. Was the pregnancy free of alcohol, smoking, and other drugs?	Yes	No – Please explain:	
3. Has your baby had any illnesses, ER or Urgent Care visits since hospital discharge?	No	Yes – Please explain	
4. Did your baby pass the hearing test done in the hospital?	Yes	No	Unsure
5. Did your baby have a Newborn Screen done in the hospital?	Yes	No	Unsure

1. Please list any medications or supplements your baby is taking: ______________________

2. Please list any major family medical issues: ______________________

____

3. Please list any known Allergies: ______________________

Staying Healthy/Safety/Dental Health/Tobacco Exposure:

1. Does your home have a working smoke detector?	Yes	No	Unsure
2. Have you turned your water temperature down to less than 120 degrees)?	Yes	No	Unsure
3. Do you always place your baby in a rear-facing car seat in the back seat?	Yes	No	
4. Does anyone smoke in or outside of the house?	Yes	No	
5. Do you always put your baby to sleep on her/his back?	Yes	No	
6. Baby sleeps…	With me	In a crib	Other- Please explain:
7. Do you have a thermometer?	Yes	No	

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Parents and Family:

Who lives at home with your child?

Name	Age	Relationship to your child	Occupation	Highest Education Level

In the past year have there been any changes in your family? (check all that apply)

- ☐ Marriage
- ☐ Separation
- ☐ Divorce
- ☐ Loss of job
- ☐ Move to new neighborhood
- ☐ Change to new school
- ☐ Serious illness
- ☐ Death
- ☐ Other changes/stresses (Please Explain): ______________________

____

2. Do you have family & friends to help out?	Yes		No	
3. Are you feeling down, depressed, irritable, or hopeless?	Not at All	Several Days	More than half the days	Nearly every day
4. Are you having little interest or pleasure in doing things?	Not at All	Several Days	More than half the days	Nearly every day

Nutrition/Physical Activity:

1. What was your baby's birth weight?	_____ lbs & _____ oz	
2. How many feedings in 24 hrs?		
2a. For Breastfeeding: How many minutes per side per feeding?		
2b. For formula/bottle feeding: How many ounces per feeding?		
2c. If you are giving formula, what brand are you using?		
3. Do you have any concerns about your baby's feeding/weight?	NO	Yes- Please explain:

Elimination:

Does your baby have at least 6+ wet diapers in 24 hours?	Yes	No – How many?
Does your baby have soft, yellow bowel movements?	Yes	No - Please Explain:
Is your baby stooling comfortably?	Yes	No - Please Explain:

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Development:

1. Does your baby regard your face (starting to focus with his/her eyes)?	Yes	No
2. Does your baby respond to voices or sounds?	Yes	No
3. Does your baby move both arms and legs equally?	Yes	No
4. Does your baby responds to your attempts of soothing them?	Yes	No
5. Do you have any concerns about how your baby sees or hears?	Yes	No

4. Do you have any concerns about your child's development, or any other concern you would like to discuss with your Provider: ______________________________

BIOLOGICAL FAMILY HISTORY

Have any FAMILY members had the following? If yes, please explain:

Childhood hearing loss	□ Yes	□ No	□ Don't know	
Nasal allergies	□ Yes	□ No	□ Don't know	
Asthma	□ Yes	□ No	□ Don't know	
Tuberculosis	□ Yes	□ No	□ Don't know	
Anemia	□ Yes	□ No	□ Don't know	
Bleeding disorder	□ Yes	□ No	□ Don't know	
Dental decay	□ Yes	□ No	□ Don't know	
Cancer (before 55 years old)	□ Yes	□ No	□ Don't know	
Liver disease	□ Yes	□ No	□ Don't know	
Kidney disease	□ Yes	□ No	□ Don't know	
Diabetes (before 55 years old)	□ Yes	□ No	□ Don't know	
Obesity	□ Yes	□ No	□ Don't know	
Alcohol abuse	□ Yes	□ No	□ Don't know	
Drug abuse	□ Yes	□ No	□ Don't know	
Mental illness/depression	□ Yes	□ No	□ Don't know	
Developmental disability	□ Yes	□ No	□ Don't know	
Immune problems, HIV, or AIDS	□ Yes	□ No	□ Don't know	
Tobacco use	□ Yes	□ No	□ Don't know	

Additional family history: ______________________________

____

____

____

Kīpuka o ke Ola

ADULT-CLINIC AGREEMENT (Rev 1/2/24)

Please read carefully and ask any questions prior to signing.

1. KOKO offers an array of services that you might benefit from. Currently our services include: primary care services, psychiatric medication management, behavioral health psychotherapy services, and transcranial magnetic stimulation (TMS) services. These services are subject to change.

2. We strive to provide all our treatment services within a Native Hawaiian cultural framework.

3. All services at KOKO are conducted, and/or overseen by, licensed professionals. Please know that with any physical or mental health service, there are associated risks. Your provider will let you know what the benefits and risks are of the services they provide - so that you can give informed consent to participate. You may elect to not participate in any service at any time. If the provider or service is not what you need or want, we can provide you with information on other known providers/services in the community. We cannot endorse providers/services outside of the KOKO Clinic, but will simply inform you of options that we are aware of.

4. Your Private Health Information is private and confidential with some specific limitations (examples: court mandates, health insurance directives, accreditation directives, mandated reporting requirements, and in-Clinic case reviews and consultations with other appropriate Clinic staff (Circle of Care).

   Please read the HIPAA Hawaii Notice Form (confidentiality) provided in your New Patient Packet. It has its own signature page separate from this Patient-Clinic Agreement signature page.

5. Our Clinic hours are generally as follows: Monday 8:15am-5:00pm and Tuesday-Friday 8:00am-5:00pm. Monday 8:00-8:15am am we are in a staff meeting. We try to have a staff person at the front desk during lunch time (12:00pm-1:00pm), though this is not always possible. There are certain holidays and staff training and development days when the Clinic is closed. Please know that some providers are employed part-time and are therefore not seeing patients every week day. Providers are not on-call after-hours for emergencies, so please call **911** and/or go straight to the nearest emergency room if you have an emergency.

   Other useful emergency numbers:

Access (suicide and crisis line) **1-800-753-6879**

National Helpline (emotional distress or suicidal crisis) **988** (will route you to local center based on your phone number area code. There are also text and chat functions.

Domestic Violence Shelters: **808-959-8864** (Hilo) and **808-322-7233** (Kona)

6. Keeping your scheduled treatment appointments is very important to getting successful health outcomes. We know there will be times you will need to reschedule an appointment. Please give more than 24 hours notice. Each provider reserves the right to terminate their provision of care to you if:

   a) frequently reschedule or cancel your appointments

   b) are chronically late to your appointment

   c) if you no-show three times.

   A "no-show" is when you do not attend your treatment session and you did not call to cancel or reschedule. If you are terminated by a provider there is a provision to submit a reconsideration for reinstatement of services.

7. You will be sent reminder messages for upcoming appointments. Please confirm your appointment when you get these reminders. If you do not confirm your appointment at least 24 hours in advance, then your appointment may be given to another patient in need. If we do give the appointment to another patient we will message you.

8. Please pay attention to your appointment ARRIVAL TIME and your appointment START TIME. Both are important and may lead to your appointment being rescheduled.

   a) For all **new** patients, ARRIVAL TIME is 30 minutes before appointment time with completed paperwork or 1 hour before appointment time without completed paperwork. In addition to completed paperwork, please bring a current picture ID and current medical insurance card.

   b) For **follow up** Well Child Visits: if they are 0 to 5 years old, MANDATORY ARRIVAL TIME is 30 minutes before appointment time or your appointment will need to be rescheduled.

   c) For **follow up** Well Woman Exams – MANDATORY ARRIVAL TIME is 30 minutes before appointment time or your appointment will need to be rescheduled.

   d) For all other **follow up** appointments, SUGGESTED ARRIVAL TIME is 15 minutes before appointment time

9. If you are late for your **follow-up** appointment START TIME your appointment will need to be rescheduled. Here are the guidelines:

a) For **follow up** appointments for Primary Care, Psychiatric Medication Management and TMS, 10 minutes late for appointment START TIME your appointment will need to be rescheduled.

b) For **follow up** appointments for Behavioral Health psychotherapy, 15 minutes late for appointment START TIME your appointment will need to be rescheduled.

10. The particular treatment service and the length of the treatment session determine how much each session will cost. If you have health insurance that KOKO accepts, then you will be charged the co-pay set by the insurance company and for any services not covered by your insurance. You are encouraged to contact your health insurance carrier for the specifics of your coverage, costs, and co-payments. Payment is expected at the time of service unless there is another arrangement KOKO and you have agreed upon. In cases of financial hardship, payment plans are available as as sliding scale fees.

    Services beyond direct treatment services are to be paid directly by client (not insurance). If you need KOKO's services for other professional services beyond the treatment services (example, report writing, treatment summaries) then you will be charged in 15 minute increments at the established hourly rate by profession.

11. Medicine refills will be called into your pharmacy within 72 hours.

12. We try to maintain good communication with our patients utilizing telephone calls, text and email messages and reminders. At times we have the ability to staff a dedicated phone operator and at times we cannot. We do ask for your patience. Please leave clear and detailed messages on our phone line as they are checked regularly and responded to within an hour if at all possible (depending on staffing and call volume). Please note: Incoming messages in late afternoon may not be received until the next day. Incoming messages in late afternoon on a Friday may not be received until the following Monday. Incoming messages on a holiday will not be received until the next open business day.

    We also have a website at www.kipukaokeola.com and have our Clinic page on Facebook and Instagram. These are information only sites and not a place to connect with KOKO staff about your care, records, or appointments.

13. If you have a need behavioral health psychotherapy records - we will provide a Brief Clinical Summary. This is to protect the patient from information that may reflect unfavorably on the patient from being reported in written form. If you want the summary provided to someone besides yourself, you must sign a consent to release information form.

14. We do not provide new clients with Workmen's Compensation evaluations, Supplemental Security Insurance assessments, or Child Custody evaluations.

15. Please do not subpoena providers and treatment records for any Court proceedings. If a provider does get subpoenaed, we will try to squash (block) the subpoena. If you do become involved in legal proceedings that mandate a provider's participation, you will be expected to pay for their professional time.

16. There are situations where two parental signatures are necessary for a child to receive treatment.

17. Providers are mandated reporters and must report any indications that child abuse and neglect may have occurred; or if a client presents as suicidal or homicidal.

18. If you want some or all of your medical records released to another party, please complete a Release of Information form.

19. If you choose to transfer care, we will have you complete a Transfer of Care form so we can provide your new provider(s) with your medical record.

20. KOKO providers and support staff will treat you with respect at all times. We ask that you do the same. If you are disrespectful to the KOKO staff, you may get a warning or, depending on the severity or the frequency, be terminated as a patient. If you have a concern or issue please do inform the staff. If they are unable to address it, they may offer for you to speak to a provider, supervisor, or management team member. There are times we cannot address an issue at the time of your complaint - but we will definitely get it to someone who can as quickly as possible. Please understand that it may take a business day to do so. If you do not get resolution and you wish to file a formal complaint - the Front Desk staff will provide you the Patient Complaint form to complete. This will go to the KOKO Compliance Officer. The complaint will be investigated within five open work days. The Compliance Officer will contact appropriate Clinic leadership of the complaint. By the sixth open business day, you will receive a response from the Compliance Officer with the outcome of the investigation. If you are dissatisfied with the outcome, you may file a complaint with our Federal Accreditor - The Compliance Team via their website at www.thecomplianceteam.org or via phone at 1-888-291-5353.

☐ Please check this box to allow KOKO to send appointment reminders and other communications via texting through our confidential electronic health record system (Tebra).

I, ______________________________(print name), have read and fully understand the above items and I agree to abide by them as conditions of receiving services at KOKO.

Signature ____ Date______________

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HIPAA - HAWAII NOTICE FORM

(Rev 1/29/18)

Notice of Policies and Practices to Protect the Privacy of Your Health Information

THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL, PSYCHIATRIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. USES AND DISCLOSURE FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

We (KOKO provider) may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

-"PHI" refers to information in your health record that could identify you "treatment, payment and health care operations".

-*Treatment* is when we provide, coordinate or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist. .
-*Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care to determine eligibility or coverage.

-*Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- "Use" applies only to activities within KOKO office such as sharing, employing, applying, utilizing, examining and analyzing information that identifies you.

- "Disclosure" applies to activities outside of our office, such as releasing, transferring, or providing access to information about you to other parties.

II USES AND DISCLOSURES REQUIRING AUTHORIZATION

We (KOKO) may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment, or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. "Psychotherapy Notes" are notes we have made about our conversation during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing and the information has not yet been disclosed.

You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. USES AND DISCLOSURES WITH NEITHER CONSENT NOR AUTHORIZATION

We (KOKO) may use or disclose PHI without your consent or authorization in the following circumstances:

1. Child Abuse: if we have reason to believe that child abuse or neglect has occurred or that there exists a substantial risk that child abuse or neglect may occur in the reasonable foreseeable future, we must immediately report the matter to the appropriate authority.

2. Adult and Domestic Abuse: If we, in the performance of my professional or official duties, know or have reason to believe that a dependent adult has been abused and is threatened with imminent abuse, we must promptly report the matter to the appropriate authority

3. Health Oversight Activities: If the Hawaii Board of Psychology is investigating our competency, license, or practice, we may be required to disclose your protected health information.

4. Judicial and Administrative Proceedings: If you are involved in a court proceeding and request is made for information about the counseling or psychotherapy services provided to you and/or the records thereof, such information is privileged under Hawaii law, and we shall not release information without the written authorization of you or your legally appointed representative or a court order. The privilege does not apply when you are

being evaluated for a third party or where the evaluation is court ordered. We shall inform you in advance if this is the case.

5. Serious Threat to Health or Safety: We may disclose your protected health information regarding you where there is clear and imminent danger to you or another individual or to society, and then only to appropriate professional workers or public authorities. If you are at risk, we may also contact family members or others who could assist in providing protection.

6. Worker's Compensation: If you have filed a worker's compensation claim, we may be required to disclose PHI about any services we have provided to you that are relevant to the claimed injury.

IV. PATIENT'S RIGHTS AND PSYCHOLOGIST'S DUTIES

PATIENT'S RIGHTS:

1. Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.

2. Right to receive confidential Communications by Alternative Means and at Alternative Locations: You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. On your request, we will send your bills to another address).

3. Right to Inspect and Copy: You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

4. Right to Amend: You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

5. Right to an Accounting: You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.

6. Right to a Paper Copy: You have the right to obtain a paper copy of the notice form from us upon request, even if you have agreed to receive this notice electronically.

PROVIDERS' DUTIES:

1. We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

2. We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

3. If we revise our policies and procedures, we will notify you.

V. COMPLAINTS

If you are concerned that we have violated your privacy rights, or you disagree with a decision we made about access to your records, please contact us directly in person or by phone at (808) 557-1596. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services, 50 United Nations, Room 322, San Francisco, CA 94102.

I, (Print Name)__________________________________, have read and understand this form and have had the opportunity to have all of my questions answered.

____ _________________

Signature Date

Kīpuka o ke Ola

Physical Address: 64-1035 Māmalahoa Hwy, Suite F Kamuela, HI 96743
Mailing Address; PO Box 818, Kamuela, HI 96743
Office: (808) 885-5900 FAX: (808) 885-6900

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

1. I hereby authorize all Kīpuka o ke Ola Providers to release/receive information to/from:

Individual/Agency: ____

Address: ______________________________ Phone and/or FAX: ________________

2. It is very important to your care that we can access necessary health records from NHCH/Queen's known as "CareLink". This access allows us for paperless transmittal of health records if you have previously been a patient at NHCH/Queen's. If you DO NOT want us to have access, please OPT OUT by initialing below.

I would like to OPT OUT of having KOKO access my CareLink records: ____________

3. Pertaining to the care of:

Last Name: _________________________ First Name: ____________________

DOB: __________ and/or Social Security #: _______-_________-________

4. For the Purpose of:

____

5. Description of information: Disclosure is authorized for any and all information about medical, personal or mental health history, mental and physical condition, including HIV infection, AIDS, or ARC, drug or alcohol use, and other personal information.

____

6. Fees A reasonable fee will be charged for duplication of records. An estimate of those charges will be provided upon request prior to duplication.

7. Duration of validity: This authorization is valid for six (6) months from the date of signing unless revoked in writing by the undersigned prior to six (6) months. I understand that the revocation will not apply to any action taken in reliance on this authorization.

8. Re-disclosure: The information used and/or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer protected.

9. Signature: I have read and agree to the disclosure of my protected health information to the above stated individual/ agency.

Date __________

Telephone ____________ Signature ________________________________