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: **Insurance #:**	**Subscriber's Name:** **Date of Birth:**
Secondary Insurance: **Insurance #:**	**Subscriber's Name:** **Date of Birth:**
Emergency Contact: **Relationship to Client:**	**Phone Number:**
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

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 www.kipukaokeola.com

KOKO PATIENT QUESTIONNAIRE - CHILD FORM

(Rev 1/29/18)

Client's Name: _____ **Date:** _____

DOB: _____

Current School: _____ Grade Level: _____

What is/are your main reason(s)/concern(s) for seeking help/assistance for your child:

_____

_____

_____

_____

Child's Medical History

Who is child's regular doctor/pediatrician: _____

Was you child born on time, i.e – full term? Yes ___ No ___

Did mother have health problems during the pregnancy? Yes__ No __ Describe:

_____

_____

Born by vaginal delivery or c/section? _____

If c/section, reason: _____

Please list problems, if any, after birth (jaundice, feeding problems, infections, etc):

_____

_____

Is your child adopted? Yes__ No __ If Yes, please describe the above to the best of your knowledge.

Has your child seen a psychiatrist, psychologist, therapist, or counselor before (Please specify name of the professional, how long your child was seeing the professional, and for what reason):

_____

_____

Has your child had any head injury or episodes of loss of consciousness before (Please specify when and reason or situation this occurred):

_____

_____

_____

_____

Does your child have any allergies (Please specify allergens (specific medicines, plants, foods, etc) and what happens with exposure (hives, shortness of breath, swelling, diarrhea, vomiting, etc):

_____

_____

_____

_____

Has your child ever had, been diagnosed or treated for any of the following illnesses (Please describe your answers on the blank space provided):

Anemia: Yes__ No __
Asthma/Breathing Problems: Yes__ No __ Allergies: Yes__ No __

Arthritis: Yes__ No __
Behavioral Problems: Yes__ No __
Bleeding Tendency: Yes__ No __
Bowel Problems: Yes__ No __ Cancer/Leukemia: Yes__ No __
Chicken Pox/Shingles: Yes__ No __ Develop. Disorder: Yes__ No __ Diabetes: Yes__ No __
Ear/Nose/Throat (ENT) Disorder: Eczema/Skin Disorder: Yes__ No __
Eye Disorder: Yes__ No __
Growth Disorder: Yes__ No __
Heart Disorder/Defect: Yes__ No __
High Blood Pressure: Yes__ No __
High Cholesterol: Yes__ No __
Immune Deficiency Disorder: Yes__ No __ Kidney/Urinary Disorder: Yes__ No __ Liver Disease: Yes__ No __
Seizure: Yes__ No __ _____
Thyroid Disorder: Yes__ No __
Any Other? Yes__ No __

Has your child had any past surgeries or hospital stays (Physical or Psychiatric) - Please specify when and for what reason:

_____

_____

_____

_____

Is your child on any medications, supplements, vitamins, or herbal remedies (Please specify what type, how much, how often, and how long your child has been on these):

_____

_____

_____

_____

Was your child exposed to drugs, alcohol, domestic violence, or other trauma during pregnancy (please specify):

_____

_____

Was your child exposed to drugs, alcohol, domestic violence, or other trauma during early childhood (please specify):

Have you had any concern with your child's development (example: walking, talking, social interactions, developing of friends, anger control, mood stability, intelligence, etc) - please specify:

Have you had any concerns with your child school or academic performance (Please Specify):

Do you have any concerns that your child is using/experimenting with drugs or alcohol (Please Specify):

Does your child have any court involvement (Please specify reason for involvement):

Has your child attempted suicide or has on-going self-injurious behavior (such as self-cutting) – Please specify:

Family Information

Guardian's Name:

Relationship to Child: _____ Occupation/ Employment:_____Approximate Age: _____

Highest Level of Education: _____

Guardian's Name:

Relationship to Child: _____ Occupation/Employment:_____

Approximate Age: _____Highest Level of Education:_____

Other Members who live with child (Siblings, Parent's Significant Other's, Foster Parents, Grandparents, etc.)

Name: _____

Relationship to Child: _____ Approximate Age: _____

Name: _____

Relationship to Child: _____ Approximate Age: _____

Please list blood relatives who have been diagnosed with the following conditions:

Alcoholism:

_____

Anxiety disorders – identify specific anxiety if known (PTSD, Panic Disorder, Phobia, OCD, Generalized Anxiety, etc.):

_____

Childhood Disorder – identify specific disorder if known (Mental Retardation, Autism, ADHD, Learning Disorders, etc.):

_____

Bipolar disorder:

_____

Cancer (type if known):

_____

Depression:

_____

Diabetes:

_____

Drug abuse:

_____

Eating Disorders – identify specific disorder if known (Anorexia, Bulimia, Over-eating, etc.):

_____

Heart disease – identify specific illness if known (High blood pressure, Heart Attack, Stroke Arrhythmias, etc.):

_____

Impulse Control and Conduct Disorders – identify specific disorder if known (ODD, Conduct Disorder, Incarceration, anger issues, etc.):

_____

Seizures – identify specific seizure disorder if known:_____

Schizophrenia:_____

Suicides (Attempted and Completed):

Thyroid disease:

Please list your child's and your family's strengths and what your child and your family like to do for fun:

Review of Systems

Is your child currently having or have he/she recently had any of these physical symptoms in the past month (please circle your responses):

Fevers

Headache

Constipation

Hot/cold flashes

Chills

Chest pain

Acid reflux

Decreased sex drive

Night sweats

Shortness of breath

Joint pains

Problems reaching orgasm

Unexplained weight loss/gain

Heart palpitations

Muscle pains or tension

Easy bruising or bleeding

Weakness in arms/legs

Cough

Pain or difficulty urinating

Rashes

Numbness in arms/ legs

Sore throat

Dental problems

Tired all the Time

Episodes of passing out

Nausea or vomiting

Changes in vision

Eye problems

Problems walking

Diarrhea

Changes in hearing

NONE OF THE ABOVE

*** PLEASE FEEL FREE TO WRITE ON THE BACK SIDE OF THIS FORM IF YOU NEED MORE SPACE TO ANSWER ANY OF THE ABOVE QUESTIONS ***

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 www.kipukaokeola.com

CHILD CLIENT-PROVIDER AGREEMENT

(Rev 12/04/2019)

Prior to beginning treatment, it is important for you to understand our approach to working with children and agree to some rules about your child's confidentiality during the course of his/her treatment. The information herein is in addition to the information contained in the Adult Client-Therapist Agreement. Under HIPAA and the APA Ethics Code, we are legally and ethically responsible to provide you with informed consent. As we go forward, we will try to remind you of important issues as they arise.

One risk of a child's participation in treatment involves disagreement among parents and/or disagreement between parents and provider regarding the best interests of the child. If such disagreements occur, we will strive to listen carefully so that we can understand your perspectives and fully explain our perspective. We can resolve such disagreements, or we can agree to disagree, so long as this enables your child's treatment progress. Ultimately, you will decide whether treatment will continue. If you decide that treatment should end, we will honor that decision, however we ask that you allow us the option of having a few closing sessions to appropriately end the treatment relationship.

Treatment services are most effective when a trusting relationship exists between the provider and the patient. Privacy is especially important in securing and maintaining that trust. On occasion, one goal of treatment is to promote a stronger and better relationship between children and their parents. However, it is often necessary for children to develop a "zone of privacy" whereby they feel free to discuss personal matters with greater freedom. This is particularly true for adolescents who are naturally developing a greater sense of independence and autonomy. By signing this agreement, you will be waiving your right of access to your child's full treatment records.

It is our policy to provide you with general information about treatment status. We will raise issues that may impact your child either inside or outside the home. If it is necessary to refer your child to another mental health professional with more specialized skills, we will share that information with you. We will not share with you what your child has disclosed to us without your child's consent. We will tell you if your child does not attend sessions. At the end of your child's treatment, we will provide you with a treatment summary that will describe what issues

were discussed, what progress was made, and what areas are likely to require intervention in the future.

If your child is an adolescent, it is possible that he/she will reveal sensitive information regarding sexual contact, alcohol and drug use, or other potentially problematic behaviors. Sometimes these behaviors are within the range of normal adolescent experimentation, but at other times they may require parental intervention. We must carefully and directly discuss your feelings and opinions regarding acceptable behavior. If we ever believe that your child is at serious risk of harming him/herself or another, we will inform you.

Although our responsibility to your child may require our involvement in conflicts between the two of you, we need your agreement that our involvement will be strictly limited to that which will benefit your child. This means, among other things, that you will treat anything that is said in session with us as confidential. Neither of you will attempt to gain advantage in any legal proceeding between the two of you from our involvement with your children. In particular, we need your agreement that in any such proceedings, neither of you will ask us to testify in court, whether in person, or by affidavit. You also agree to instruct your attorneys not to subpoena us or to refer in any court filing to anything we have said or done.

Note that such agreement may not prevent a judge from requiring our testimony, even though we will work to prevent such an event. If we are required to testify, we are ethically bound not to give our opinion about either parent's custody or visitation suitability. If the court appoints a custody evaluator, guardian ad litem, or parenting coordinator, we will provide information as needed (if appropriate releases are signed or a court order is provided), but we will not make any recommendation about the final decision. Furthermore, if we are required to appear as a witness, the party responsible for our participation agrees to reimburse us at the following rates per hour for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs: Mental Health Counselor = $85, Clinical Psychologist = $200, Nurse Practitioner = $415, Family Practice Medical Doctor = $460, and Psychiatrist = $460. You will also be charged for applicable taxes. Services that require less than one hour will be pro-rated in 15-minute increments.

Signature Acknowledgement & Agreement

Abbreviated Contract Draft

- If you decide to terminate treatment, we have the option of having a few closing sessions with your child to properly end the treatment relationship.
- You are waiving your right to access to your child's full treatment records - instead a brief treatment summary will be provided.

- We will inform you if your child does not attend the treatment sessions.
- At the end of treatment, we will provide you with a summary that includes a general description of goals, progress made, and potential areas that may require intervention in the future.
- If necessary, to protect the life of your child or another person, we have the option of disclosing information to you without your child's consent.

• You agree that our role is limited to providing treatment and that you will not involve me in any legal dispute, especially a dispute concerning custody or custody arrangements (visitation, etc.).
• You also agree to instruct your attorneys not to subpoena us or to refer in any court filing to anything we have said or done.

- If there is a court appointed evaluator, and if appropriate releases are signed and a court order is provided, we will provide general information about the child which will not include recommendations concerning
  custody or custody arrangements.

- If, for any reason, we are required to appear as a witness, the party responsible for our participation agrees to reimburse us at the following rates per hour (plus applicable taxes; pro-rated in increments of 15 minutes) for time spent traveling, preparing reports, testifying, being in attendance, and any other case-related costs: Mental Health Counselor = $85, Clinical Psychologist = $200, Nurse Practitioner = $415, Family Practice Medical Doctor = $460, and Psychiatrist = $460

FORMAL COMPLAINTS: If you wish to file a formal complaint about some aspect of your experience at KOKO, please ask the Front Desk staff for a Patient Complaint form. When you complete this form please return the form to the Front Desk staff who will give it to the agency Associate Director/RHC Compliance Officer. You will receive a written notification of receipt of complaint. The complaint will be investigated within five working days. The Associate Director will contact appropriate Clinic leadership of the complaint and will convene the Quality Improvement group to address the complaint. On the sixth working day after the complaint is filed, you will receive a response from the Associate Director as to the outcome of the investigation. In the event your complaint remains unresolved with KOKO, you may file a complaint with our Accreditor, The Compliance Team, Inc via their website: www.thecomplianceteam.org or via phone 1-888-291-5353.

DISPUTE RESOLUTION: All disputes arising out of or in relation to this agreement to provide treatment services shall first be referred to mediation, before, and as a pre-condition of, the initiation of arbitration. The mediator shall be a neutral third party chosen by agreement of myself and client(s). The cost of such mediation, if any, shall be split equally, unless otherwise agreed upon. In the event that mediation is unsuccessful, any unresolved controversy related to this agreement should be submitted to and settled by binding arbitration.

LITIGATION LIMITATION: Due to the nature of the treatment process and the fact that it often involves making a full disclosure with regard to many matters which may be of a confidential nature, it is agreed that should there be legal proceedings (such as, but not limited to divorce and custody disputes, injuries, lawsuits, etc..), neither you (client's) nor your attorney's, nor anyone else acting on your behalf will call on us to testify in court or at any other proceeding,

I, _____ (print name) HAVE READ AND AGREE TO THE POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF MY HEALTH INFORMATION.

_____ _____

Signature Date

_____ Relationship to child

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 www.kipukaokeola.com

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

SUMMARY OF IMPORTANT INFORMATION FOR KOKO CLIENTS (Rev 2/7/18)

1. Providers are not available after hours. If there is an emergency, call 911 and/or go straight to the nearest emergency room.

2. Treatment services will be provided within a Native Hawaiian cultural framework.

3. Three missed appointments may lead to termination of services. If services are terminated by you or KOKO, and you wish to have services in the future, then you must apply for reinstatement of services.

4. There is a $25 fee paid directly by client for cancellations (under 24 hrs) and no-shows.

5. If client is 10 or more minutes late for **psychiatric** or **primary care visits**, it is considered a no show. If a client is 20 min or more late for a **psychotherapy visit**, it is considered a no show.

6. Medicine refills will be filled within 72 hours.

7. If you have a need for medical records - only a Brief Clinical Summary will be provided. If you want the summary provided to someone besides yourself, you must a consent to release information form.

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

9. Services beyond direct treatment services are to be paid directly by client (not insurance).

10. Providers and treatment records are not to be subpoenaed for any Court proceedings.

11. 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.

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

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

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. I hereby authorize exchange of information between KOKO & the electronic health record of NHCH/Queen's known as "CareLink". This allows for paperless transmittal of health records if you have previously been a patient at NHCH/Queen's.

Please initial here for consent: _____

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 unless otherwise specified below:

_____

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 _____