Blane K. Chong
Family & Sports Medicine
3221 Waialae Avenue, Suite 390
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Ph 808.732.9710
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REGISTRATION FORM

Today's Date:	

PATIENT INFORMATION

Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Is this your legal name?		If not, what is your legal name?	(Former name):	Birth date:	Age:	Sex:	
☐ Yes	☐ No					☐ M	☐ F

Street address:	Social Security no.:	Main phone no.:
		( )

P.O. box:	City:	State:	ZIP Code:

Occupation:	Employer:	Employer phone no.:
		( )

Ethnicity:	☐ Hispanic or Latino	☐ Not Hispanic or Latino	☐ Decline

Race:	☐ White	☐ Black or African American	☐ American Indian or Alaska Native	☐ Asian	☐ Native Hawaiian or Pacific Islander	☐ Decline

Language:

In Case of Emergency:

Full Name:	Relationship to patient:	Cell phone no.:

INSURANCE INFORMATION

Person responsible for bill:	Birth date:	Address (if different):	Home phone no.:
			( )

Is this person a patient here?	☐ Yes	☐ No	Is this patient covered by insurance?	☐ Yes	☐ No

Is this patient covered by secondary insurance?	☐ Yes	☐ No	Please indicate primary insurance:

Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Policy no.:	Co-payment:
				$

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

Name of secondary insurance (if applicable):	Subscriber's name and birth date:	Telephone no.:	Policy no.:

Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other	

ALLERGIES	
List any/all known allergies: ☐ No Known Allergies	
MEDICATION HISTORY	
List any/all medications: ☐ No Known Drug Allergies	
ACTIVE PROBLEMS	
List any active medical problems:	
PAST MEDICAL HISTORY	
List any past medical problems:	
PAST SURGICAL HISTORY	
List any past surgical procedures:	
FAMILY MEDICAL HISTORY	
Please list family member relationship with medical history:	1.
	2.
	3.
	4.
	5.
	6.
	7.

SOCIAL HISTORY		
Tobacco Use:	☐ Current Every Day Smoker	☐ Current Some Day Smoker
	☐ Former Smoker : Date Quit:_____	☐ Never A Smoker
Alcohol Use:	☐ Current Alcohol User ☐ Social ☐ Occasional	Frequency _____/day _____/week
	☐ Never Drank Alcohol	☐ Stopped Drinking Alcohol

To the best of my knowledge, the above information is correct and true. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance whether or not paid by said insurance. I understand that I will be assessed the bank charge for each check returned due to insufficient funds. In the event of default, I (We) promise to pay legal interest on the indebtedness, together with such collection costs and reasonable attorney fees as may be required to effect collection of this note. I also authorize Blane K. Chong, M.D., or its representatives, Akamai Practice Management, or insurance company to release any information required to process my claims, including the diagnosis and the records of any treatment or examination rendered to me during this period of such medical or surgical care. I hereby, assign all medical/surgical benefits to include major medical benefits to which I am entitled, including Medicare, Tricare West, private insurance, and any other health plan to Blane K. Chong, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I authorize and approve my signature as an electronic signature. I hereby authorize Blane K. Chong, M.D to release all information necessary to secure payment and treatment.

CONSENT TO TREATMENT

I authorize and consent to medical care and treatment, completed by Blane K. Chong, M.D., that my treating

provider finds to be necessary and which is given or performed at his or her direction. I understand that any requests or restrictions related to my treatment must be discussed with my provider.

FINANCIAL AGREEMENT

Financial Responsibility

I understand that it is my financial responsibility to pay anything my insurance does not cover. Health insurance companies do not pay for everything, even some care that I or my healthcare provider have good reason to think I need. I consent to treatment and will pay any charges not covered by my insurance company. If I have questions regarding coverage, I will contact my health insurance company directly.

Assignment of Insurance Benefits and Payment:

I understand that I am responsible for paying my bill in full. If I am entitled to any insurance benefits, I assign all benefits to Blane K. Chong, M.D. toward payment of my bill and direct my insurance carrier to pay these benefits to Blane K. Chong, M.D. Blane K. Chong, M.D. will bill my insurance carrier if I provide the appropriate information in a timely fashion.

NO SHOW POLICY

Missed appointments or appointments cancelled within 24 hours prior to the scheduled appointment time are considered No Show Appointments. No show appointments will result in a penalty fee of $25.00. After the first No Show visit, a letter will be sent to the patient regarding our No Show policy stating that a $25 fee will be applied for each following No Show appointment. I understand that I am responsible for paying the fee in full, and this charge cannot be billed to my insurance.

Collection:

If a bill is not paid within 90 days (or longer if required by law), I understand that Blane K. Chong, M.D. may refer the matter to an attorney and/or collection agency, and I will be responsible for paying all legal fees and other costs incurred to collect my bill.

If I have CHAMPUS coverage:

I request payment to Blane K. Chong, M.D. of authorized benefits for all services furnished me by Blane K. Chong, M.D**.**

If I have Medicare coverage:

I certify that the information given to me in applying for payment under Medicare is correct. I authorize the Social Security Administration to release information on my Medicare effective dates and Medicare Claim number to Blane K. Chong, M.D. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any information needed for this or any related Medicare claim. I request that payment of benefits be made to Blane K. Chong. M.D. on my behalf.

NOTICE OF PRIVACY PRACTICE

My signature below confirms that I have been given a copy of the Blane K. Chong, M.D. Notice of Privacy Practice.

RELEASE OF INFORMATION:

I understand that my health information for this course of treatment may be disclosed for the purpose of treatment, for obtaining payment from my insurers and other payors, and for other qualified health care operations, within the limits of the law. I further understand that certain specific categories of my health information require Consent before release. If my medical records for this course of treatment contain any information related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), mental health diagnosis and treatment, and/or treatment in a federally funded substance abuse treatment program. I Consent to release such health information for the purpose of treatment, for obtaining payment from my insurers and other payors, and for other specific insurer/payor requirements, within the limits of the law.
I certify that I have read this Consent and that I am the patient, or the patient's authorized representative, and I accept and agree to be bound by the Consent, a copy of which will be made available upon request.

Patient/Guardian signature *Date*

Authorization for Verbal Communication and Permission to Invite me to Participate in Elation Patient Portal

This does not authorize release of copies of medical records without a signed Authorization to Release Medical Records form by patient or guardian.

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Patient Information

Name- (Last, First, MI)	Date of Birth:
Address:	

Current Telephone Numbers

Home Phone:	Cell Phone:
Work Phone:	Other Phone:

Confidential Voicemail:
Please initial below where we have your permission to leave confidential voicemail regarding any medical information (e.g. lab results, prescription refills, etc.)

Home Phone _____ Cell Phone_____ Work Phone_____ Other Phone_____

Your protected Health Information Designees:
If you are not available at the time we call, please list those individuals (designees) below with whom we can leave a brief message with or discuss any medical information (e.g. lab results, prescription refills, etc). This designee will also be able to contact our office directly on your behalf.

Please print the name and relationship to you of each designee below:

Designee Name:	Relationship to patient:	Contact #:
Designee Name:	Relationship to patient:	Contact #:

____ Initial here if you ***do not want*** us to discuss your medical information with anyone other than yourself.

Information for Elation Patient Portal:
Please provide an email address below to which we can send you an invitation to participate in our new Elation Patient Portal. This portal provides you the ability to communicate with our staff and Dr. Chong regarding appointments, prescriptions, test results, questions, and viewing or updating personal information.

Email Address:

Your signature below confirms your approval of these updated HIPAA communication preferences. You may change your selections at any time, but must do so by completing an updated form.

_____ _____

SIGNATURE OF PATIENT OR GUARDIAN DATE SIGNED