Personal information about you is needed so we can prepare Federal & State reports and to contact you if necessary.

ALL INFORMATION WILL BE KEPT CONFIDENTIAL

Name: Last:	First:	Middle:	Birth Date: / /
Previous Last Name if any:	Nickname:	Soc. Sec. #: - -	Current Gender: Male ☐ Female ☐
Mailing Address:	City:	State:	Zip:
Street Address:	City:	State:	Zip:
Home Phone: ( )	Day Phone: ( )	Alternate Phone: ( )	Secondary Phone: ( )	Cell Phone: ( )
E-mail Address:	Marital Status: Single ☐ Married ☐ Divorced ☐ Legally Separated ☐ Widowed ☐ Life Partner ☐			
Preferred Contact: Home Only ☐ Day Only ☐ Cell Only ☐ No preference ☐	Do you have a Living Will or Advanced Directive? Yes ☐ No ☐ **Insurance:** Medicare ☐ Medicaid ☐ Private Insurance ☐			
Student Status: Full Time ☐ Part Time ☐ Not a Student ☐	Are you a Veteran? Yes ☐ No ☐	Do you smoke? Yes ☐ No ☐	U.S. Citizen: Yes ☐ No ☐ COFA Migrant☐	Preferred Language: ☐ English ☐ Other: _____
Family Size and Income:	Gross monthly income: $_____ Number of people supported: _____ Refused to report ☐ Initials: _____	Head of Household: Self ☐ Spouse ☐ Head of Household *if a minor:* Father ☐ Mother ☐ Other ☐		
Housing Status: Street/Homeless ☐ Rent ☐ Doubling Up ☐ Own ☐ Sheltered ☐ Transitional ☐	Are you Hispanic or Latino? Yes ☐ No ☐	Migrant Worker Status: Migrant ☐ Seasonal ☐ Not a Migrant ☐		
Race / Ethnicity: (Select all that apply)	African American/Black ☐ Native Hawaiian ☐ Refused/Unreported ☐	American Indian/Alaskan Native ☐ Other Pacific Islander ☐	Asian ☐ White ☐	
Religion: (Select One)	Buddhist ☐ Catholic☐ Christian☐ Hindu☐ Islamic☐ Jehovah's Witness☐ Mormon☐ Muslim☐ Nazarene☐ Scientology☐ Other☐ Unknown☐ None☐ Refused☐			

SOGI [Sexual Orientation & Gender Identity] [*for reporting purposes only]*

Sex Assigned at Birth: Male ☐ Female ☐	Gender Identity: Male ☐	Female ☐	Other ☐	Choose not to Disclose ☐
	Male to Female [Trans Woman/MTF] ☐		Female to Male [Trans Man/FTM] ☐	
Preferred Pronoun:	He/Him/His ☐	They/Them/Theirs ☐	Other ☐	
	She/Her/Hers ☐	Declined to Answer ☐	N/A ☐	
Sexual Orientation:	Straight ☐	Gay/Lesbian ☐	Bi-Sexual ☐	Choose not to Disclose ☐ Don't Know ☐
Something else, please describe:				

Referral Source

How did you hear about Bay Clinic? [please choose one]

BCI Website ☐	Health Fair/Event ☐	Internet Search Engine ☐	Word of Mouth ☐
Newspaper ☐	Social Media [Facebook, Twitter, etc.] ☐		Yellow Pages ☐

Original: 03/02/21 W. Foley
Revision: 04/12/21 W. Foley; 05/06/21 R. Payne; 07/09/21 R. Payne

If the PATIENT is a minor, please provide Parent/Legal Guardian information

Father's/Legal Guardian's Full Name:	Mother's/Legal Guardian's Full Name:
Date of Birth: / /	Date of Birth: / /
Spouse's Name:	Spouse's Name:
Parent/Legal Guardian Marital Status: Life Partner ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced ☐	Mother's maiden name or Legal Guardian's relationship to the patient:

Minor lives with:	Mother ☐	Father ☐	Both ☐ Other:

Parent/Legal Guardian mailing address:		Check if same as child ☐
City:	State:	Zip:
Best contact phone #: ( )	E-mail Address:	

Emergency Contact Information

Name of person we may contact in case of an emergency:	Relationship:	Phone #: ( )
*** May we discuss your health with your emergency contact?**	**Yes ☐**	**No ☐**
Please list any other person[s] we may talk to about your health:		
Name:	Relationship:	Phone #: ( )
Name:	Relationship:	Phone #: ( )

Responsible Party Information

[Enter information of person financially responsible for account if other than self]

Last Name:		First Name:	MI:
Phone: ( )	Date of Birth: / /	Relationship to Patient: Spouse ☐ Parent/Legal Guardian ☐	Other:
Mailing Address [Billing]:			
City:		State:	Zip:

Patient Portal

The Patient Portal supports secure communication with your Healthcare team by providing convenient access from the comfort and privacy of your own home. The Patient Portal allows you to view your medical history, lab results,appointments, and request prescription refills from your provider.

Would you like to sign up for Bay Clinic, Inc.'s Patient Portal access and receive secure communication?

Yes ☐ No ☐ Enrolled ☐

Please read and initial each statement below.
(Your initials indicate that you have read, understand, and acknowledge the statement).

INITALS

_____ I hereby acknowledge that I have had an opportunity to have my questions answered and have received the Bay Clinic, Inc. "**Notice of Privacy Practices"**

[STAFF ONLY] □ Patient refused to sign "Notice of Privacy Practices Acknowledgement ". Staff Initials: _____

_____ I hereby acknowledge that I have received a copy of Bay Clinic, Inc. **"Patient Rights and Responsibilities"**.

_____ I hereby acknowledge that I have received a copy of Bay Clinic, Inc. "**Prescription Guidelines & Appointment Policies"**

INITALS **Consent to Treat**

_____

∗ I hereby give Bay Clinic, Inc. consent to obtain historical information, perform physical exams, order diagnostic tests and administer medical, dental or mental health treatment as deemed appropriate. This includes, but is not limited to: obtaining medical, dental and mental health histories, performing exams, minor procedures, TB skin tests, injections of local anesthetics, and medications, immunizations and all other ordinary medical / dental office procedures.

∗ I understand that for procedures not listed above, I will be provided with verbal and/or printed materials regarding the additional treatment. I also understand that no treatment will be given to me without signed consent by me for those procedures other than ordinary medical / dental office procedures.

∗ In case[s] of emergency, I give permission for Bay Clinic, Inc. to render any such medical / dental services deemed necessary to stabilize my condition if I am physically or mentally impaired and no adult family member is available. I release Bay Clinic, Inc. from liability that may arise as the result of such treatment.

∗ I understand that Bay Clinic, Inc. provides comprehensive primary, dental and mental healthcare for all patients regardless of ability to pay.

∗ I am not consenting to experimental procedures or tests solely for research or scientific study purposes.

∗ My photograph may be used for medical and dental record purposes only.

∗ I authorize Bay Clinic, Inc. to release information to third party payors, health, dental and social services agencies and to Medicare. I authorize Bay Clinic, Inc. to bill by charges to Medicare. I understand that I am responsible for my medical and dental expenses regardless of my health and dental insurance status.

∗ I understand that I must provide written documentation as proof of income and proof of any health and dental insurance information. If I do not provide this documentation, or falsify information, Bay Clinic, Inc. reserves the right to terminate my health and dental services.

INITALS **Patient Information Acknowledgement**

_____

* I agree to be responsible for all charges that are not directly paid by my insurance company and I authorize Bay Clinic, Inc. to release information to my payor to process claims on my behalf. I authorize payment of medical benefits to Bay Clinic, Inc. for services rendered. I certify the information I have provided is true and correct to the best of my knowledge. I understand it is illegal to falsify information on this form.

* I authorize Bay Clinic, Inc. to call my residence or cell phone for appointment reminders. If I am not available, I authorize Bay Clinic, Inc. to leave a message which will identify Bay Clinic, Inc. and will include the date and time of my appointment.

Signature Attestation and Acknowledgement

I certify that I have read **ALL** of the above statements [or have had them read to me] and I fully understand the information provided to me.

* My signature below certifies that I am of legal age [18 or older] or am an emancipated minor by the definition of State Laws.

_____ Patient Name [Printed]

_____ Parent/Guardian Name [Printed]

_____ Patient Signature or Parent/Guardian Signature

_____ Signature Date

_____ Staff Witness Name [Printed]

_____ Staff Witness Signature

_____ Date

Original: 03/02/21 W. Foley
Revision: 04/12/21 W. Foley; 05/06/21 R. Payne; 07/09/21 R. Payne

BAY CLINIC, INC.
NETWORK OF FAMILY HEALTH CENTERS

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully**.

YOUR RIGHTS

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communication	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say, "yes" to all reasonable requests.

Ask us to limit what we use or share	• You can ask us not to use or share certain health information for treatment, payment, or our operations.
	  ○ We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  ○ We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why • We will include all the disclosures except for those about treatment, payment, and • health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• If you feel we have violated your rights, you can file a report by contacting our Compliance Officer at 450 Kilauea Ave. Ste. 105, Hilo, HI 96720 or (808) 333-3600.

BAY CLINIC, INC.
NETWORK OF FAMILY HEALTH CENTERS

YOUR CHOICES

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations describe below, talk to us about what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choices to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts • If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
In these cases, we never share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Mental Health (including psychotherapy notes) • HIV related information (AIDS related testing) • Substance Abuse (including alcohol/drug abuse)
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	*Example:* A doctor treating you for an injury asks another doctor about your overall health condition.
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	*Example:* We use health information about you to manage your treatment and services.
Bill for services	• We can use and share your health information to bill and get payment from health plans or other entities.	*Example:* We give information about you to your health insurance plan so it will pay for your services.

How else we can use or share your health information? We are allowed or required to share your information in other ways - usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.bhs.gov/ocr/privac,/bipaa/understanding/consumers/index.html.

BAY CLINIC, INC.
NETWORK OF FAMILY HEALTH CENTERS

Help with public safety issues	• We can share health information about you for certain situations such as: ○ Preventing disease ○ Helping with product recalls ○ Reporting adverse reactions to medications ○ Reporting suspected abuse, neglect, or domestic violence ○ Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director upon the death of an individual.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: ○ For workers' compensation claims ○ For law enforcement purposes or with a law enforcement official ○ With health oversight agencies for activities authorized by law ○ For special government functions such as military, national security, and presidential protective services.
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This "Notice of Privacy Practices" applies to the following organizations:

Bay Clinic, Inc. Administrative Office
450 Kilauea Avenue Suite 105
Hilo HI 96720

Hilo Family Health Center
1178 Kino'ole St.
Hilo, HI 96720

Hilo Women's Health Center
73 Pu'uhonu Pl.
Suite 204
Hilo, HI 96720

Hilo Family Dental Center
1257 Kilauea Ave.
Suite 100
Hilo, HI 96720

Hilo Pediatrics
450 Kilauea Ave.
Suite 103
Hilo, HI 96720

Ka'u Family Health and Dental Center
95-5583 Mamalahoa Hwy.
Na'alehu, HI 96772

Kea'au Family Health and Dental Center
16-192 Pili Mua St.
Kea'au, HI 96749

Pahoa Family Health Center
15-2866 Pahoa Village Road
Bldg C Suite A
Pahoa, HI 96778

Pahoa Women and Children's Health Center
15-2866 Pahoa Village Road
Bldg F Suite A
Pahoa, HI 96778

Mobile Health Unit
15-2866 Pahoa Village Road
Bldg C Suite A
Pahoa, HI 96778

Call Center
(808) 333-3600

BAY CLINC, INC.

NETWORK OF FAMILY HEALTH CENTER

Patient Rights and Responsibilities

YOUR RIGHTS:	YOUR RESPONSIBILITIES:
To choose your Primary Care Provider. In cases when your PCP is not available, you will be served by another qualified healthcare professional.	To be considerate and cooperative with Bay Clinic, lnc. staff.
To know the name and job title of individuals directly involved inproviding your healthcare.	To provide a thorough medical history, and any other applicable information that your medical provider may request.
To view your medical records by scheduling an appoint-ed time and date for review, and to receive a copy for a nominal fee.	To ask questions or to seek clarification to adequately understand your illness and/or treatment.
To receive respectful and competent treatment regard- less of your race, color, religion, gender, sexual preference, disability, national origin, primary language, health status, or source of income.	To schedule appointments, to arrive on time for your appointments, and to notify us at least twenty-four (24) hours in advanced if you must cancel or be late for your appointment.
To receive high quality healthcare in clean and well-maintained facilities.	To understand the coverage your health insurance plan provides.
To be treated in a manner reflecting respect for your privacy and dignity as a person and to have all personal information about you or your family kept confidential.	To follow through with recommendations made by the medical providers, and to keep your follow-up appointments.
To be informed about your diagnosis, treatment, and options in terms and language you can reasonably be expected to understand.	To notify your provider as soon as possible of any side effects from medication, or if yourhealth worsens after your visit.
To receive enough information to enable you to give informed consent before beginning any procedure or treatment.	To fulfill your financial obligations by making appropriate payments, and/or to pay your portion of the bill for services.
To refuse treatment, drugs or other procedures recommended by your healthcare provider to the extent permitted by law, and to be made aware of the potential medical consequences of refusing treatment.	To live a healthy lifestyle.
To have your medical records treated confidentially, and to know that your records with not be released without your consent unless otherwise provided by law.	Bay Clinic, lnc. staff are committed to ensuring that all patients are treated fairly, and receive the best quality healthcare possible. We encourage patients to become familiar with their rights and responsibilities.
To be informed about changes in Bay Clinic, Inc.'s policies and procedures that may affect you as a patient.	**WHO TO CONTACT REGARDING CONCERNS:**
To express your satisfaction or dissatisfaction with Bay Clinic, lnc. staff or services, and if dissatisfied, to be informed of our patient grievance procedures. You have the right to expect a response to a complaint within a reasonable period of time.	You should contact the Charge Nurse at the clinic you are visiting, and they will route your concern to the appropriate staff member.

LOCATIONS:

Bay Clinic, Inc. Administrative Office
450 Kilauea Avenue Suite 105Hilo HI 96720
(808) 333-3600

Hilo Family Health Center
1178 Kino'ole St.
Hilo, HI 96720

Hilo Women's Health Center
73 Pu'uhonu Pl.
Suite 204
Hilo, HI 96720

Hilo Family Dental Center
1257 Kilauea Ave.
Suite 100
Hilo, HI 96720

Hilo Pediatrics
450 Kilauea Ave.
Suite 103
Hilo, HI 96720

Ka'u Family Health and Dental Center
95-5583 Mamalahoa Hwy.
Na'alehu, HI 96772

Kea'au Family Health and Dental Center
16-192 Pili Mua St.
Kea'au, HI 96749

Pahoa Family Health Center
15-2866 Pahoa Village Road
Bldg C Suite A
Pahoa, HI 96778

Pahoa Women and Children's Health Center
15-2866 Pahoa Village Road
Bldg F Suite A
Pahoa, HI 96778

Mobile Health Unit
15-2866 Pahoa Village Road
Bldg C Suite A
Pahoa, HI 96778

Call Center
(808) 333-3600

Original: 09/27/2006
Revision: 02/21/2019; 05/06/2021 R. Payne

Bay Clinic, Inc.
Network of Family Health Centers

PRESCRIPTION GUIDELINES & APPOINTMENT POLICIES

Prescription Guidelines

All prescription refills must be approved by your provider and may require up to 3 business days to process. PLEASE plan ahead. Prescription refills will only be approved if your provider feels it is safe for you to receive a refill without coming in for an office visit.

Appointment Policy

Our health center is here to serve our community and meet the need for primary health care services. Our patients are typically seen by appointment. Walk-ins may be seen based on available clinic resources.

We will call to confirm your appointment up to three days prior to your schedule appointment date.

Please arrive and check in for your appointment(s) as follows:

New Dental or Medical Patient (not seen within the last 2 years)	40 minutes prior to your scheduled appointment time
Established Dental or Medical Patient (seen at Bay Clinic within the last 2 years)	20 minutes prior to your scheduled appointment time
First Obstetrics Appointment	1 hour prior to your scheduled appointment time

In the event we are unable to confirm your appointment, your appointment may be double booked. Please ensure your information on file is accurate and up to date.

Cancellation/No Show Policy

We understand that sometimes you need to cancel or reschedule your appointment. If you cannot come to your appointment, please call us to reschedule or cancel your appointment at least 24 hours in advance. Failure to reschedule/cancel your appointment at least 24 hours in advance may result in a 'no show'. Three 'no show' appointments in a six-month period will result in your ability to only be seen as a "same day" appointment, which can be resolved once you keep three consecutive appointments or as deemed necessary by the provider.

If you call us and get the voicemail, please do not hang up. Leave the following information:

- Your first and last name and phone number
- The reason you are rescheduling/cancelling your appointment
- The date and time of your appointment

Initial:09/27/06
Revised: 12/29/10, 04/27/2021 RP

BAY CLINIC, INC.

NETWORK OF FAMILY HEALTH CENTERS

Authorization for Release of Information

RECEIVE RECORDS

Patient Last Name:	Patient First Name:		Middle Initial:
Maiden or Other Name	Birthdate:	Social Security #:	
Mailing Address:	City:	State:	Zip:
Home phone #:	Work phone #:	Cell phone #:	

I hereby authorize:

Name			
Address:	City:	State:	Zip:
Phone:	Fax:		

To: □ SEND □ SHARE (DISCUSS) □ SEND/SHARE (DISCUSS)
with Bay Clinic, Inc.
Please mail or fax information to:

INFORMATION TO BE RELEASED: DATES:

- □ OV – last year _____
- □ Most recent labs _____
- □ Last mammogram _____
- □ Last colonoscopy _____
- □ Last hospitalization within 2 years _____
- □ Most recent immunization list _____
- □ Imaging test results for the last year _____
- □ Most recent ECG _____
- □ Dental Notes _____
- □ Dental X-Ray _____
- □ Other: _____

I specifically authorize the release of information relating to:

Please Initial:

- □ Substance Abuse (including alcohol/drug abuse) _____
- □ Mental Health (including psychotherapy notes) _____
- □ HIV related information (AIDS related testing) _____

X_____ _____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

PURPOSE OF DISCLOSURE: □ Changing Physicians □ Consultation/Second Opinion □ Continuing Care
□ Legal
□ Other (please specify): _____

1. This authorization is valid for release of Protected Health Information for 180 days from the date below OR as indicate:
   □a one-time disclosure □upon termination from services □until revoked □Other: _____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].
4. I understand that in compliance with State of Hawaii § 622-57 (g), I will pay a fee of $_____(Print the Fee Charged). There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

_____ _____ _____ _____
SIGNATURE OF PATIENT DATE OR PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_____ _____ _____
RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT

FOR OFFICE USE ONLY

DATE REQUEST FILLED:_____ BY: _____

IDENTIFICATION PRESENTED:_____ FEE COLLECTED: $_____