Kimberly Lund, D.O. Dawn Uithol, M.D. Sherrie Hirota, M.D. Jenny Satterberg, M.D.

Please Print

Name: ____

Last First Middle Initial

Home Address: ____

Number Street City State Zip Code

Billing Address: ____

Number Street City State Zip Code

Phone Numbers: Home ______________ Work ______________ Cell ______________
(Circle preferred number)

Email Address: ______________________ Marital Status: [ ] Single [ ] Married [ ] Widowed [] Divorced

Date of Birth: _____/ _____/ _____ Social Security: _____-_____-_____ Male [ ] Female [ ]

Employers Name: ____

Language: [ ] English [ ] Other: ______________ Race/Ethnicity: ____________________

Responsible Party (if applicable-who will be receiving your billing statement):

Name: ____

Last First Middle Initial

Date of Birth: _____/_____/_____ Relationship to Patient ______________________

In Case of an Emergency, who do you wish us to contact?

Name: ______________________ Phone: ______________ Relationship_________

Name: ______________________ Phone: ______________ Relationship_________

Medical Insurance Information:

Primary Insurance ______________________ Subscribers Name _____________ DOB________

Subscriber ID#: ______________________ Group _____________ Plan# ______________

Secondary Insurance ______________________ Subscribers Name _____________ DOB________

Subscriber ID#: ______________________ Group _____________ Plan# ______________

I authorize release of any information concerning my (or my child's) healthcare, advice, and treatment for the purpose of evaluating and submitting claims for insurance benefits. I also authorize payment of insurance benefits directly to Trade Winds Family Medicine. I understand that I am responsible for any amount not covered by insurance.

Signature: ______________________________________ Date: __________________

What we ask of you as we partner with you to provide your medical care:

1. Please pay charges at time of service
   - Charges include co-payments, co-insurance payments, and deductibles as well as any charges for services that are not covered by your health insurance plan.
   - For patients with health insurance plans, we file a claim to your primary insurance carrier to receive payment for your visit. If your health insurance plan does not provide reimbursement of the claim within 60 days after your appointment, the unpaid balance will become your responsibility.
2. Missed appointments/late cancellations
   - Trade Winds Family Medicine staff will contact and remind you one to two days before your scheduled appointment.
   - Please arrive 15 minutes before your appointment time is scheduled for the check-in process. We strive to ensure that your appointment begins at the time that it is scheduled, and the check in process occurs prior to your appointment.
   - If you are unable to make your appointment, we would like to know as soon as possible so that we can allow another patient to receive care during that scheduled time. Please call us 24 hours or more in advance if you need to cancel or reschedule your appointment.
   - If you miss your appointment, or do not call to cancel or reschedule at least 24 hours before your appointment, we will request a $50 missed appointment fee. Of course, we understand that sometimes the unexpected does occur and results in a missed appointment. In order to continue to provide the level of care that we do, we rely upon you to assume the responsibility of such instances and reimburse us for the time that was allotted for your care. All federal or state funded insurance participants, such as the Quest program, will be asked to find a different physician if we experience 2 no shows or late cancellations under 24 hours notice per calendar year.
3. Medications
   - We require that all prescriptions for medications be written during an office visit. We feel that calling in refills for prescriptions allows an increase in the possibility of making medical errors, as well as does not give us the opportunity to assess your response to the therapy.
   - We will make every effort to ensure that your prescriptions are written correctly and in sufficient quantity to last until your next office visit.

970 N. Kalaheo Avenue, Suite C-306, Kailua, Hawaii 96734
Ph. 808.263.1922 Fax. 808.263.1922

Non-covered benefits

- Occasionally patients may request certain professional services that may not be covered by health insurance plans. A fee may be assessed for such services.
- Examples include:
    i. Patient requested written correspondence
    ii. Copying/printing medical records
    iii. Faxing or mailing prescriptions
    iv. Other fax services

4. Minor patients
    - A minor must be accompanied by a parent or legal guardian during his/her office visit.
5. Returned checks
    - We request a $25 service fee on all returned checks.
6. Delinquent accounts
    - Accounts past due will be placed on a cash only status, at which time all balances due must be paid in full at each visit.

I have read and understand this document and agree to abide by its terms. All of my questions regarding this document have been explained to me.

I understand that charges not covered by my health insurance plan, or not paid to Trade Winds Family Medicine within 60 days of the service rendered, as well as any applicable fees, co-payments, and deductibles, are my responsibility.

I authorize my insurance benefits to be paid directly to Trade Winds Family Medicine. I authorize Trade Winds Family Medicine to release pertinent medical information to my insurance company when requested to facilitate payment of a claim.

Most importantly, thank you for allowing us to participate in the preservation of your health!

______________________________ __________________

Signature of patient or responsible party Date

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NOTICE OF PRIVACY POLICIES

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.

WHO WILL FOLLOW THIS NOTICE:

This notice describes our practices and that of:

- Any health care professional authorized to enter information into your chart,
- All departments and units of Trade Winds Family Medicine,
- All employees, staff and other personnel of Trade Winds Family Medicine.

All these entities, sites and locations follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment, or operations purpose described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION:

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive at Trade Winds Family Medicine. 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 Trade Winds Family Medicine. This notice will tell you about the ways in which we regard the use and disclosure of medical information.

We are required by law to:

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

HOW WE ARE REQUIRED BY LAW TO DISCLOSE MEDICAL INFORMATION ABOUT YOU:

We will disclose medical information about you when required to do so by federal, state or local law:

- **To Avert a Serious Threat to Health or Safety.** We will use and disclose medical information about you when we have a "Duty to Report" under state or federal law, because we believe that it is 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 threat.

- **Public Health Risks.** We will disclose medical information about you for public health reporting required by federal or state law. 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 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 Client 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.

I have read, understand, and agree with the above statements:

_________________________   _________________________

Signature   Date

MEDICAL HOME Patient-Provider Partnership Agreement

Aloha!

Thank you for choosing Trade Winds Family Medicine. We are committed to partnering with you to help you achieve the best health that you can.

Trade Winds Family Medicine is designated a "patient-centered medical home" practice. This means that we will provide you with an expanded type of care. We will work with you and any other health care providers that you may have as a team. You will have access to your health information via an on-line patient portal. You will be able to communicate securely on-line with Trade Winds Family Medicine front office staff via this patient portal.

*****ONLINE PORTAL**

You will be able to communicate securely online with Tradewinds Family Medicine front office staff via the online portal.

As your primary care provider and your care team, we will:

- Learn about you, your family, life situation, health goals and preferences. We will suggest treatments that make sense for you, given all these factors.
- Take care of any short-term illnesses, long-term chronic diseases, and provide preventive health support and guidance.
- Keep you up-to-date on all your vaccines and preventive screening tests.
- Connect you with other members of your care team (specialists, health coaches, etc.) and coordinate your care with them as your health care needs change.
- Communicate clearly with you so you understand your condition(s) and all your options.
- Listen to your questions and feelings. We will respond promptly to you in a way you understand.
- Help you make the best decisions for your care.
- Give you information about classes, support groups, or other services that can help you learn more about your condition and stay healthy.
- Provide a written visit summary at the end of your visit (or within 3 days of your visit if not yet completed, and you request it)

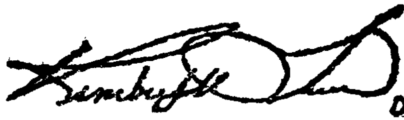
We trust you, as our patient, to:

- Know that you are a full partner with us in your care.
- Provide updates at your visits on medications, dietary supplements, or remedies you're using, and prepare questions that you may have.
- Let us know when you see other health care providers so we can help coordinate the best care for you.
- Keep scheduled appointments and be on-time, or call to reschedule or cancel with a minimum of 24 hours notice.
- Tell us when you don't understand something, so that we may explain it to you.
- Learn about your condition(s) and what you can do to stay as healthy as possible.
- Follow the plan that we have agreed is best for your health.
- Take medications as prescribed.
- Contact us after hours only if your issue cannot wait until the next working day (and not for medication refills, please plan in advance for this).
- For non-emergent care, contact Trade Winds before going to the emergency room clinic so someone who knows your medical history can care for you.

- Agree that all health care providers on your care team will receive all information related to your health care.
- Learn about your health insurance coverage and contact your insurance company if you have questions about your benefits.
- Pay your share of any fees.
- Give us feedback to help us improve our care for you.

We look forward to working with you as your primary care provider in your Patient-Centered Medical Home.

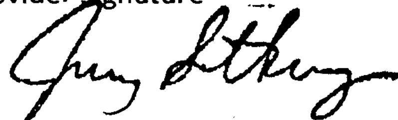
☐ I Choose Dr. Kimberly Lund to be my PCP
☐ I Choose Dr. Dawn Uithol to be my PCP
☐ I Choose Dr. Sherrie Hirota to be my PCP
☐ I Choose Dr. Jenny Satterberg to be my PCP



Provider Signature	Printed Provider Name	Date
D.O.	Kimberly Lund, D.O.	

Provider Signature	Printed Provider Name	Date
	Dawn Uithol, M.D.	

Provider Signature	Printed Provider Name	Date
	Sherrie Hirota, M.D.	



Provider Signature	Printed Provider Name	Date
	Jenny Satterberg, M.D.	

Patient Signature	Printed Patient Name	Date

Parent/Guardian Signature	Printed Parent/Guardian Name	Date

***Cell Phone Number** ______________________________

*** Email Address** ______________________________

*By providing your cell phone number and/or email address, you consent to your PCMH care team contacting you regarding your medical care via cell phone or email.

Kimberly Lund D.O.
Dawn Uithol M.D.
Sherrie Hirota M.D.
Jenny Satterberg, M.D.

970 North Kalaheo Ave. Ste C-306
Kailua, Hawaii 96734
Phone (808) 263-7383 Fax (808) 237-5828

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

(is anyone other than you authorized to request your health information – such as a friend or family member?)

Patient's Name: ______________________ Date of Birth: ______________

Previous Name: ______________________ Social Security #: ______________

I request and authorize TRADE WINDS FAMILY MEDICINE to release healthcare information of the patient named above to:

Name: ____

Address: ____

City: ____________________ State: ______ Zip Code: ______________

Relation: ____________________ Phone: ____________________

This request and authorization applies to:

- ☐ Healthcare information relating to the following treatment, condition, dates:
  ____
- ☐ All healthcare information
- ☐ Other: ____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS, and gonorrhea.

Please circle one:
YES NO I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person listed above. I understand that the person listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

YES NO I authorize the release of any records regarding drugs, alcohol, or mental health treatment to the person listed above.

Patient Signature: ______________________________ Date: ______________