GI Health Hawaii
Jeong H. Kim, M.D.
Gastroenterology

Welcome and thank you for choosing GI Health Hawaii.

Name : _____ _____ ❑ M ❑ F
Last First

Birthdate (mm/dd/yy) : _____/_____/_____ Age : _____

Social Security # : _____

Address : _____

_____ _____ _____
City State Zip

Home Phone # : _____ Cell Phone # : _____

Email Address : _____ Referring Doctor : _____

Emergency Contact : _____ Relation : _____

Emergency Contact Phone # : _____ Alternate Phone # _____

Financial Agreement:

_____
Initials

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company. I authorize the release of any information necessary to process insurance claims to my insurance companies and for payment to be made directly to Dr. Jeong H. Kim, MD, PLLC.

- **Please note that some screening visits and/or procedures may not be covered. Please check with your insurance company *prior* to your appointment to fully understand your benefits.**

I have completed the above information to the best of my knowledge and I will notify the office of any changes to the information I have provided.

Signature : _____ Date : _____/_____/_____

1401 S. Beretania St. Suite 320 Honolulu, HI 96814 P (808) 888-0967 F (808) 888-0956

GI HEALTH Hawaii
JEONG H. KIM, M.D.
GASTROENTEROLOGY

PATIENT HIPAA CONSENT FORM

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and I, understand that this information serves as:

- a basis for planning my care and treatment
- a means of communication among the many health professionals who contribute to my care
- a source of information for applying my diagnosis and surgical information to my bill
- a means by which a third-party payer can verify that services billed were actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any family member?	YES	NO

If YES, please name the members allowed:

_____

_____ Accepted _____ Denied Reason for denial: _____

Printed Name : _____ Date: _____

Signature of Patient/Legal Representative Witness : _____

If above is signed by a witness other than the patient:

* Name printed (if not above) : _____*Relation to Patient: _____

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