**PARENT/LEGAL GUARDIAN (if under 18 years of age):**

Name: _____ Relationship: _____ Phone: _____

**AUTHORIZATION AND RELEASE**

I consent to any diagnostic and or medical treatment (including voluntary family planning services) under the instruction of the provider for which my dependent, listed below or I have sought care.

Name: _____ DOB: _____

Relationship: _____ Phone: _____

**Signature:** _____ **Date:** _____

**Initials:** _____ I give Hamakua Health Center, Inc. permission to verify the financial and insurance information provided by me, to determine eligibility. I understand it is my responsibility to keep Hamakua Health Center, Inc. informed of any changes in my family income and insurance status.

**Initials:** _____ I authorize Hamakua Health Center, Inc. (HHC, Inc.) to release to my insurance company any information necessary to secure insurance payment. I also authorize the use of this signature on all insurance submissions. I understand I am responsible for all charges regardless of insurance coverage. All co-pays and balances are due at the time of visit.

**Initials:** _____ I authorize payment be made directly to HHC, Inc. by my insurance company for all services provided to me.

**Initials:** _____ I give my consent to Hamakua Health Center, Inc. departments (medical, dental, behavioral health, education, case management) to share information so my family and I will receive the best integrative care.

The information provided is accurate and complete to the best of my knowledge and is only to be used for my treatment, billing, and/or for qualification for services to which I may be eligible.

_____ _____

**Signature (Patient/Responsible Party/Legal Guardian)** **Date**

Print name: _____ Relationship: _____

# PATIENT CONSENT FORM

I give my consent and authorization to Hamakua Health Center, Inc. to release any information regarding my diagnostic/ medical treatment, and financial status to the person(s) listed below.

Name: _____ Phone: _____

Relationship: _____ DOB: _____

Name: _____ Phone: _____

Relationship: _____ DOB: _____

**Patient's Signature:** _____ **Date:** _____

May we say that it is the Hamakua-Kohala Health when we contact you?
[ ] Yes [ ] No, then what is the best way to contact you? _____

May we leave appointment reminders on your voicemail at the phone number(s) indicated on the Patient Information form?
_____ Yes _____ No, how would you like to be notified? _____

*** If you a here for a **confidential** visit, please provide us with a phone number where we can reach you.

_____