Fetal Diagnostic Institute of the Pacific
1600 Kapiolani Boulevard, Suite 1025
Honolulu, HI 96814
Telephone: 808-945-BABY (808-945-2229)
Fax: 808-945-2230

Date _____

Registration/Consent Form

PATIENT INFORMATION (*Required)

*Name_____ Maiden Name_____
Last Name First Name Middle Name

*Date of Birth_____ * Phone_____ Cell/Home

*Address_____

City_____ State_____ Zip_____

*Email:_____

Patient Employer_____ Occupation_____

Emergency Contact_____ Relation_____ Phone_____

Referring Physician: _____
(Specify location if doctor has multiple offices)

PRIMARY INSURANCE

***SUBSCRIBER NAME**_____
Last Name First Name Middle Name

Relation to patient_____ ***BIRTHDATE**_____

Address (if different from patient's)_____Phone_____

City_____ State_____Zip_____

***MEDICAL INSURANCE NAME:**_____SUBSCRIBER#:_____

***DRUG COVERAGE**:_____DRUG COVERAGE CODE:_____
(If different from medical plan)

ADDITIONAL INSURANCE

Is patient covered by additional insurance? ___Yes ___No

SUBSCRIBER NAME_____

Relation to patient_____ ***BIRTHDATE**_____

Address (if different from patient's)_____ Phone_____

City_____ State_____Zip_____

***MEDICAL INSURANCE NAME:**_____SUBSCRIBER#:_____

***DRUG COVERAGE**:_____DRUG COVERAGE CODE:_____
(If different from medical plan)

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INSURANCE ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with_____
Name of insurance company (ies)
and assign directly to Dr. Greigh I. Hirata all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named physician may use my health care information and may disclose such information to the above named Insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian, or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian, or Personal Representative Relation to Patient

Consent for Treatment with this Service: I hereby authorize the physician in charge of the care for myself to administer any treatment or procedures as may be deemed necessary or advisable in the diagnosis and treatment of my illness/condition.

Release of Information: The physician is: a) authorized to furnish from patient's record requested information or excerpts to any insurer of patient for the purpose of remuneration of the physician services provided the insured;
b) authorized to relay pertinent medical information to other physician(s) involved in the patient's previous and continuous care.

Financial Agreement: The undersigned agrees whether he signs as agent or as patient that in consideration of the services to be rendered to the patient he hereby individually obligates himself to pay the account of the physician in accordance with the regular rates and terms of the physician. Should the account be referred to an agency for collection, the undersigned shall pay reasonable fees and collection expenses. All delinquent accounts bear interest at the legal rate.

The undersigned certifies that she/he has reviewed/completed and understands the foregoing, and is the patient, or is duly authorized by the patient's general agent to execute the above and accept its terms.

X_____ Relationship to Patient_____
Patient/Authorized Person's Signature

Date Signed_____ Time_____ AM PM

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT FORM.

I, _____, have received a copy of the Fetal
Patient Name

Diagnostic Institute of the Pacific's Privacy Practices.

_____ _____
Signature of Patient Date

06/29/2018