ACKNOWLEDGEMENT OF RECEIPT OF PAYMENT & INSURANCE FINANCIAL POLICY

By signing, I acknowledge that I have read, received, understand and agree to 'Ekahi Health's Payment and Insurance Financial Policy.

_____ _____ /_____ /_____

Patient Signature Date

_____

Print name of patient

'Ekahi Health Center
500 Ala Moana Blvd Suite 6-D
Honolulu, HI 96813
P: (808) 777-4000 F: (808) 447-0571

'EKAH1Health

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been notified of 'Ekahi Health's "Notice of Privacy Practices" (the "Notice"). It is posted in your office, and I was informed that I may also obtain a printed copy of the Notice from your office if desired.

By signing below, I acknowledge that I have been offered and reviewed a copy of the Notice for 'Ekahi Health.

_____ _____ /_____ /_____

Patient Signature Date

_____

Print name of patient

'Ekahi Health Center
500 Ala Moana Blvd Suite 6-D
Honolulu, HI 96813
P: (808) 777-4000 F: (808) 447-0571

'EKAH1Health

AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

Participant Name: _____
DOB: _____ /_____ /_____

I authorize 'Ekahi Wellness to:

- ☐ Release information to _____
- ☐ Receive information from _____

Specific person and contact information _____

_____

I authorize the release of the following information:

____☐Medications used in treatment
____☐Treatment goals/progress notes
____☐Other – please specify: _____

The purpose or need for the disclosure of information is:

- ☐ Diagnostic/evaluation/referral
- ☐ Treatment planning/ongoing treatment
- ☐ Coordination of services
- ☐ Other – please specify: _____

I understand that, unless withdrawn, this authorization will expire 1 (one) year from the date of signature. A photocopy of this form will be considered valid and original.

_____ : _____ /_____ /_____

Full Name Date

_____

Signature

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