OHANA COUNSELING SERVICES, INC.

PATIENT INFORMATION

Legal Name:________________________________ Gender:____________

Preferred Name:________________________________ Preferred Pronouns:____________

Mailing Address: ____

Date of Birth: ____________________ Primary Phone: ________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Email (Optional):____

Legal Guardian (If Applicable):____________________ Relationship to Patient:____________

Employer (If Applicable):____

School Attending (If Applicable):________________________________

Person to contact in case of emergency: ________________________________

Relationship to Patient:________________________ **Phone Number:**____________

Insurance Information: (Check if applicable) ☐ Medicare ☐ Med-Quest

Primary Insurance Company:____________________ Member ID#:________________

Guarantor Information (Person responsible for payment other than yourself)

Guarantor Name: ________________________ Relation to Patient:________________

Guarantor Phone Number and Address:____

I authorize the release of any medical or other information necessary to process my claims. I also request payment of government benefits either to myself or to the party who accepts assignment below.

I authorize payment of medical benefits to the provider that I’m being seen by.

____ ______________________

Patient’s or Authorized Person’s Signature Date

CONSUMER RIGHTS

- To be treated with dignity and respect.
- To have an individualized treatment plan and be part of the development process of that treatment plan.
- To have their records kept confidential.
- To have access to their records.
- To be informed as the possible negative side-effects of their treatment.
- To be informed of alternative treatment options.
- To participate in the grievance process without fear of reprisal.
- To refuse treatment.

Consumer Responsibilities

- To actively participate in their treatment
- To respect themselves, other people, and the property of others.
- To make timely payments on all fees for services rendered.
- To inform Ohana Counseling Services if they are unable to come to scheduled appointments within 24 hours of their appointment.
- To inform Ohana Counseling Services of any changes to their current address, phone number, and health insurance status.

Grievance Process

1. Complaints and grievances expressed by consumers should initially be handled by the staff member on duty. Consumers shall be informed that they are free to contact the Protection and Advocacy Agency of Hawaii (808.885.7789)
2. If resolution of the problem is not achieved to the satisfaction of the consumer, refer the consumer to the coordination of the program. At this state, the complaint should be placed in writing by the consumer or consumer representative.
3. If resolution I still not achieved, the coordinator of the program is to assist the consumer in arranging a meeting with the clinic director. The clinic director is the final step in the internal grievance process.

I acknowledge that I have been informed of my rights and responsibilities, as well as, the grievance process as a consumer of Ohana Counseling Services.

________________________________ ____________________

Patient Signature Date

OFFICE POLICIES

COVID-19 SAFETY

BE PROACTIVE IN YOUR SAFETY AND THE SAFETY OF OTHERS

If you are experiencing flu symptoms or have been exposed to someone who is positive or may potentially be positive for covid, DO NOT ENTER OUR OFFICE.
Please reschedule your appointment **via phone or email**.

- Patients who choose to wait in our waiting room are required to wear a mask at all times regardless of your vaccination status
- There should only be 4 (four) patients in the waiting room at a time.
- We ask that your significant others, children, and friends DO NOT enter our office. They must wait outside.
- Adults accompanying minors or those needing extra assistance are allowed
- Sanitize your hands upon entry

INTOXICATION AND UNDER THE INFLUENCE

In the event that you attend your appointments under the influence of any substances (prescribed or otherwise) we have the right to refuse our services to you. You may also be subjected to a Urinary Analysis at the time of your arrival.

APPOINTMENT POLICY

All patients must reschedule or cancel appointments within 24 hours of their originally scheduled time and date. If you are unable to comply, you may be subjected to a ***$50.00 reinstatement fee***. The reinstatement fee will allow you to make another appointment with your provider.

If you miss an appointment without 24 hour notice, we have the right to discharge you from our office. If you are late to your appointment, providers may ask that you reschedule your appointment.

COURTSEY CALLS

In the event that we are unable to call you the day before your appointment as a reminder, you are still responsible for showing up at your scheduled time. This is a courtesy call and should not be relied on.

RESPECT AND BEHAVIOR

We ask that you treat your counselor and the staff of Ohana Counseling Services with respect. It is your responsibility to behave in a respectable manner while in our office. Lack of respect and cooperation will not be tolerated. If you are unable to comply, we will discharge you from our office.

DHS/First to Work Compliance Agreement
(For those who apply)

DHS (Dept of Human Services) and FTW (First To Work) compliance paperwork must be brought to your scheduled appointments with your providers.

Ohana Counseling Services will no longer be faxing or mailing any forms. We will not be holding on to any paperwork or storing them in your files. All patients are responsible for their own paperwork and ensuring that it is completed in a timely manner.

MEDICAL INSURANCE

You must inform our office of any medical insurance changes

If your medical insurance changes to a company that is not accepted by your provider or any provider in our office, we will refer you to someone outside of our office. If you do not have medical coverage, we will need to remove you from your providers' schedule. When your medical has been reinstated, please contact the office.

By signing this, you have read and agree to the terms listed above.

____ ________________________
Patient Signature Date

CULTURAL INTAKE

Each individual has a unique social identity based on their membership within various social categories. As your counselor, I strive to acknowledge and respect every aspect of who you are and consider it a privilege to hold a safe space for you to express your authentic self. I recognize that multiple aspects of social identity creates both privilege and marginalization in society, which contributes to the diverse perspectives and experiences of each person. Within the counseling relationship, I aspire to demonstrate cultural sensitivity to your worldview, and to avoid imposing our own beliefs and values in our interactions.

By providing the following information, you will help me to gain a more comprehensive understanding of how you identify yourself, which can be explored further in our sessions.

If you feel uncomfortable or don't know how to answer any of the questions, you do not need to answer them.

Name:______________________________

Preferred name (if different):______________________________

Date of Birth: **Age:** **Race/Ethnicity:**______________________________

Gender:__________ **Preferred Pronouns:**________________ **Sexual Orientation:**________________

Religion & Spirituality (If any):________________________ **Military Experience (if any):**___________

Socioeconomic Status: When thinking about your current income, education, and occupation, which category of socioeconomic status (i.e., lower, middle, upper) do you most identify with?

____

Developmental or Other Disability: Do you identify as someone living with a visible or nonvisible disability (e.g., chronic pain, psychiatric, learning disability, etc)?

____

Indigenous Heritage: Do you belong to a native tribe or nation, for example, Native Hawaiian, First Nations, Alaska Native, or American Indian?

____

National Origin: Where were you born? ______________________________

Where were you raised (if different)? ______________________________

What are your strengths? ______________________________

Is there anything else you think would be helpful for me, as your counselor, to know?

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