P. Douglas Nielson, MD
Health Center
BYU–H # 1728
55-220 Kulanui Street, Bldg. 5
Laie, HI 96762-1293
Ph.: (808) 675-3510 Fax: (808) 675-3506

PATIENT INFORMATION SHEET

Patient Name: _____ Birth Date: _____
LAST FIRST MI MONTH DAY YEAR

Parent/Guardian Name (if pt. under 18 years old): _____

Local/School Address: _____ Local Ph.: ( ) _____

Home Address: _____ Home Ph.: ( ) _____

Social Security #: _____ - _____ - _____ Gender: Male/Female Marital Status: _____

Employer: _____ Work Ph.: _____ BYU–H ID #: _____

Account #: _____

INSURANCE INFORMATION: Please fill in the appropriate insurance information.

DMBA STUDENT INSURANCE

Insured's BYU–H ID#: _____

DMBA ID #: _____

Name: _____

Birth date: _____

OTHER/PRI. INSURANCE

Insurance Co.: _____

Policy Holder: _____

Policy Holder Birth date: _____

Policy Holder S.S. #: _____

Group #: _____

Address of Ins. Co.: _____

EMERGENCY CONTACT:

In case of emergency, please notify: _____ Ph.: _____

Relationship to Patient: _____

PERMISSION TO BE TREATED:

- I authorize the physicians and nurses employed by the BYU–Hawaii Student Health Center to provide to me reasonable and proper medical care as defined by today's standards.
- In accordance with Act 206 1995, I understand that I have a choice whether or not to have my symptom(s) or condition listed on my prescription label. Please indicate your preference:

_____ I give permission to have my symptom(s) or condition listed on my prescription label.

_____ I **DO NOT** wish to have my symptom(s) or condition listed on my prescription label.

Signature: _____ Date: _____
PATIENT, PARENT OR LEGAL GUARDIAN

BYU–Hawaii Health Services

MEDICAL HISTORY FORM

Patient Name: _____ Age: _____ Birth date: _____
please print

Medical History: To be completed by the patient/parent/legal guardian and reviewed by your health care provider. Information on this form and in your medical records is confidential and can only be released to a third party with your written authorization.

Past Medical History
Major illnesses (list, date) _____
Surgeries " _____
Hospitalization " _____
Injuries " _____

Allergies to medications/food (list med/food and type of reaction): _____
_____
_____

Current medications and dosage: _____
_____
_____

Habits
Diet: Number of meals/day: _____ Any special dietary restrictions? _____
Exercise: type of exercise: _____ number of hours/week: _____

General
Recent change in weight? _____ Have you ever vomited for weight control? _____
Have you ever participated in any activities that would put you at risk of getting AIDS/HIV? _____
Have you ever put drugs into your veins? _____
Do you think you have problems with depression? _____ nervousness/anxiety? _____ weakness/fatigue? _____

Females
_____ Age menses began
_____ # of pregnancies
_____ # of deliveries
_____ # of abortions (miscarriages or induced)
Menses every _____ days
_____ Spotting between periods
_____ Vaginal itching
_____ Days of bleeding
_____ History of sexually transmitted disease?
_____ Birth control method _____
_____ How often do you examine your breasts?

Males
_____How often do you examine your testicles for masses?
_____ Testicular masses
_____ Sores on penis
_____ Testicular pain
_____ Discharge from penis
_____ History of sexually transmitted diseases

Have you ever had or have a family history of:

Y N 1. Heart disease/surgery?
Y N 2. Diabetes or sugar in the urine?
Y N 3. A goiter or other thyroid disease?
Y N 4. High blood pressure?
Y N 5. Excessive bleeding?
Y N 6. A tumor, growth, cyst or cancer?
Y N 7. A dependency on medications or drugs?
Y N 8. A stroke?
Y N 9. Professional counseling for emotional problems?
Y N 10. Medication/hospitalization for emotional problems?
Y N 11. Tuberculosis?
Y N 12. A knee injury?
Y N 13. Limb loss or other deformities?
Y N 14. Arthritis or swollen, painful joints?
Y N 15. A back injury or deformity?
Y N 16. A pain or pressure in the chest?
Y N 17. Asthma or wheezing?
Y N 18. Stomach or intestinal ulcers?
Y N 19. Seizures, convulsions or epilepsy?
Y N 20. Kidney disease or stones?
Y N 21. A suicide attempt?
Y N 22. Anorexia or bulimia?

Do you have or have experienced THIS YEAR:

Y N 1. Ear pain or any problems with hearing?
Y N 2. Eye discomfort or difficulty seeing?
Y N 3. Frequent headaches?
Y N 4. Dizziness or fainting spells?
Y N 5. Hay fever or nasal problems?
Y N 6. Food allergies?
Y N 7. Hives or skin allergies?
Y N 8. Skin sores or rashes?
Y N 9. Warts or sores on feet?
Y N 10. A lump, new or changing mole?
Y N 11. Coughing, frequent sore throat?
Y N 12. Spitting or coughing up blood?
Y N 13. Sweating at night?
Y N 14. Stomachaches, burning or indigestion?
Y N 15. Urinary burning, frequent urination or dark urine?
Y N 16. Difficulty starting urine stream or dribbling problem?
Y N 17. Pain in back, neck or joints?
Y N 18. Difficulty walking, running or lifting?
Y N 19. Hernia?
Y N 20. Unexplained weight loss?
Y N 21. Frequent diarrhea, constipation or unusual bowel movement?
Y N 22. Pain or bleeding when having bowel movements?
Y N 23. Any illness or injury not already noted?

Explain any "yes" answers on a separate sheet (see receptionist).

BYU–HAWAII HEALTH CENTER OFFICE POLICY

OFFICE HOURS

The Health Center is open Monday through Friday between the hour of 8:00 a.m. – 12:00 p.m. and 2:00 p.m. – 5:00 p.m. Patient appointments are scheduled during these times.

APPOINTMENTS

- Patients are seen by appointment only. Walk-in patients will be scheduled for an appointment upon availability. If you require immediate medical attention, please call the Health Center as early in the day as possible so that arrangements can be made to accommodate your health care needs.
- If you are unable to keep your scheduled appointment, please let us know as far in advance as possible. Your thoughtfulness will allow us to accommodate other patients who may wish to be seen.

BILLING OF SERVICES AND CLAIMS FILING

Charges for services are billing monthly. The Health Center participates with the following insurance carriers:

- DMBA – Student Plan, Managed Care, and Student Plan through BYU
- Blue Cross/Blue Shield
- HMSA
- HMSA Quest
- Medicare

Insurance payments for these plans will be made directly to the Health Center. Any amount due after insurance payments have been posted will be billed to you. Our participation with these insurance companies does not guarantee insurance payment. **You are financially responsible for any services rendered at the Health Center that are denied payment from your insurance company. You must pay your balance in full by the end of each semester in order to register for the next semester.**

OTHER INSURANCE

- We required a $10 co-payment at the time of service.
- An insurance claim will be sent to you within two weeks of the date of service so can file the claim directly with your insurance company and receive reimbursement for those services.
- You are financially responsible for any services rendered at the Health Center and are given until the end of the current semester to pay all debts owed in full.

MEDICATION REFILLS

- The Health Center requires 24 hours notice for refill requests, except in cases of emergency.
- If you are on routine medications, please check your medication supply before ordering refills to make sure you have enough medication to last 48 hours prior to ordering.

IN CASE OF EMERGENCIES

The Health Center is closed in the evenings, weekends and holidays. For life-threatening emergencies when the Health Center is closed, go immediately to the closest emergency room or call 911 to request an ambulance. The closest emergency room to Laie is Kahuku Hospital. If after-hour urgent medical advice is needed, please call the BYU – Hawaii Security Office at 675-3911. The Security Office will be able to help you reach after-hour advice medical personnel.

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NOTICE OF CONFIDENTIALITY PRACTICES

This notice deals with the sharing of information from your medical records. PLEASE READ CAREFULLY.

This notice describes your confidentiality rights as they relate to information from your medical records and explains the circumstances under which information from your medical records may be shared with others. The information in this notice also applies to others covered under your health plan, such as your spouse or children. If you do not understand the terms for this notice, please ask for further explanation (Chapter 323c HRS).

- YOUR RIGHTS

  Under the new HIPPA law, you have the right to:

  - Inspect and request copies of your medical records or to appeal any denial of your request for inspection or copying.
  - Request that your health care provider append information to your medical record.
  - Receive a notice of your privacy rights by your health plan upon enrollment, annually and when their confidentiality practices are substantially amended.
  - Obtain a copy of this office's confidentiality practices.

- USES OF INFORMATION

  This office uses your protected health information to provide you with health care services. Under the law, your health information may also be used by such entities as health plans for the following purposes.

  - Payment to physicians and hospitals who provide you with health care.
  - Conducting quality assurance activities or outcomes assessment.
  - Reviewing the competence or qualification of health care professionals.
  - Performing accreditation, licensing or credentialing activities.
  - Analyzing health plan claims or health care records data.
  - Evaluating provider clinical performance.
  - Carrying out utilization management.
  - Conducting or arranging auditing services in accordance with statute, rule or accreditation requirements.

  Except for the purposes outlined above, your health information may not be disclosed without your authorization.

- LIMITING DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

  You have the right to limit disclosure of your protected health information if you choose to not use any health insurance or other third party payment as payment for services. In which case, you may only limit disclosure if you have advised the physician prior to the delivery of services and have paid for the health care services yourself.

I, the undersigned, state that I have read, understood and agree to all the terms listed above, **including the Notice of Confidentiality Practices**.

Signature: _____ Date: _____

PATIENT, PARENT OR LEGAL GUARDIAN

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE PERMISSION TO RELEASE MEDICAL INFORMATION TO PARENT(S)/SPOUSE/OTHER

FOR OFFICE USE ONLY
Patient Name: _____
Account #: _____
Date of Visit: _____

By signing this form, you acknowledge that the BYU – Hawaii Health Center has given you a copy or you have been offered a copy of the BYU – Hawaii Student Health Center's Notice of Privacy Practices which explains how your health information will be handled in various situations.

If your first date of service with us was due to an emergency, we must try to give you this notice and get your signature acknowledging receipt of this notice as soon as we can after the emergency. If you have any questions, please feel free to talk with one of our personnel.

Check all that are true:

☐ I have received the BYU–Hawaii Health Center's Privacy Notice.
☐ The BYU – Hawaii Health Center has given me the chance to discuss any concerns and questions about the privacy of my health information.

I give permission to the BYU – Hawaii Health Center to release information from my medical records to (print name of parent(s), spouse or other):

Name: _____ Relationship: _____
Name: _____ Relationship: _____

Signature: _____ Date: _____
PATIENT, PARENT OR LEGAL GUARDIAN (if signed by other than individual, state relationship)

BYU–Hawaii Health Center staff should complete if Acknowledgement Form is not signed:

1. Does patient have a copy of the Privacy Notice? ☐ Yes ☐ No
2. Please explain why the patient was unable to sign an Acknowledgement Form:
   _____
   _____
   _____

Signature: _____ Date: _____
Health Center Staff Member