MALCOLM R. ING, M.D., INC.
****Patient Information Form**

Referred By:_____

_____
Family Members who are patients here

PLEASE PRINT LEGIBLY

PATIENT NAME: _____ _____ _____ SEX: (circle one) M F
Last **First** **Middle Initial**

SOC SEC#: _____--_____--_____ BIRTHDATE: _____/_____/_____ MARITAL STATUS: _____ AGE: _____

ADDRESS_____ _____ _____ _____ _____
Street **Apt #** **City** **State** **Zip Code**

HOME PHONE# (_____)_____-_____ CELL PHONE# (_____)_____-_____ WORK PHONE# (_____)_____-_____

EMPLOYMENT STATUS: (CIRCLE ONE) Part time Full Time Retired Not-employed Self Employed Active Duty Unknown

STUDENT STATUS: (CIRCLE ONE) Full time Part time

EMPLOYER: _____ OCCUPATION _____

ALLERGIES (Foods/Drugs): _____

****

RESPONSIBLE PARTY

NAME_____RELATIONSHIP TO PATIENT_____ BIRTHDATE: _____/_____/_____

ADDRESS_____ _____ _____ _____ _____
Street **Apt #** **City** **State** **Zip Code**

HOME PHONE# (_____)_____-_____ CELL PHONE# (_____)_____-_____ WORK PHONE# (_____)_____-_____

INSURANCE INFORMATION

PRIMARY INSURANCE **(MUST BE COMPLETED)**

PRIMARY INSURANCE_____ ID # _____ COV CODE_____

POLICY HOLDER: _____ D.O.B: _____/_____/_____ RELATIONSHIP_____

NAME OF PRIMARY CARE PHYSICIAN/HEALTH CENTER: _____

SECONDARY INSURANCE

SECONDARY INSURANCE_____ ID # _____ COV CODE_____

POLICY HOLDER: _____ D.O.B: _____/_____/_____ RELATIONSHIP _____

NAME OF PRIMARY CARE PHYSICIAN/HEALTH CENTER: _____

THIRD INSURANCE: Please check here if you have a 3rd or 4th insurance ☐

EMERGENCY CONTACT **(OTHER THAN RESPONSIBLE PARTY)**

Name_____Relationship_____ Home phone # (____)_____-_____

****

ASSIGNMENT OF BENEFITS: I hereby authorize my physician to submit claims for benefits, for services rendered or for services to be rendered from this day forward, without obtaining my signature on each and every claim to be submitted for myself and/or dependants. I hereby authorize my insurance company to pay and hereby assign directly to **MALCOLM R ING, M.D. INC** all benefits, if any, otherwise payable to me for his services as described on the providers claim.

RELEASE OF INFORMATION: I hereby authorize the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents.

AGREEMENT: I have received the pa I understand I am financially responsible for all charges incurred. I understand that I will be fully responsible for the deductible or non-covered services that I incur. In the event of default, I agree to pay all cost of collections.

TREATMENT CONSENT: I hereby give my permission for myself/dependent to receive services and treatment at **MALCOLM R. ING M.D., INC.**

SIGNATURE:_____ **DATE:**_____

HEALTH HISTORY INFORMATION

NAME: _____ DATE: _____

What is your chief complaint/reason for appointment?

_____

_____

_____

_____

_____

YOUR HEALTH HISTORY: Have you in the past or are you now being treated for any of the following diseases? **X = YES.**

- ❑ **Anemia**
- ❑ **Asthma/Hay Fever**
- ❑ **Bleeding tendency**
- ❑ **Diabetes**
- ❑ **Rheumatic Fever**
- ❑ **Bronchitis/Pneumonia**
- ❑ **Liver Disease**
- ❑ **Jaundice**
- ❑ **Glaucoma**
- ❑ **Cancer or tumor**
- ❑ **Epilepsy**
- ❑ **Veneral Disease**
- ❑ **Tuberculosis**
- ❑ **Emphysema**
- ❑ **Stroke**
- ❑ **High Blood Pressure**
- ❑ **Heart Trouble**
- ❑ **Gout**
- ❑ **Kidney/Bladder Trouble**
- ❑ **Ulcers**
- ❑ **Nervous Breakdown**
- ❑ **Arthritis**
- ❑ **Diverticulitis**
- ❑ **Thyroid Trouble**
- ❑ **Other** _____
- ❑ **Use Tobacco**
- ❑ **Drink Alcohol**
- ❑ **Glaucoma**

Allergy to medications, please list: _____

_____

Medications taken regularly, please list: _____

_____

MAJOR HOSPITALIZATIONS: List hospitalizations or any serious illness or operation, excluding normal pregnancies

_____

_____

_____

Malcolm R. Ing, MD, Inc.
1319 Punahou Street, Suite 1110
Honolulu, Hawaii 96826

Patient Race and Ethnicity Form

As of January 1, 2012, doctors' offices are required by law to report the race and ethnicity of their patient population.

We ask that you assist us in providing this information by making the most appropriate selection regarding race and ethnicity from the choices listed below:

Ethnicity (select one):

_____ **HISPANIC**	A person who identifies with or is of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin.
_____ **NON-HISPANIC**	Any possible options not covered in the above category.
_____ **UNKNOWN**	A person who cannot declare ethnicity.
_____ **REFUSE TO REPORT**	

Race (select one):

____AMERICAN INDIAN OR ALASKAN NATIVE	____NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER
____ASIAN	____CAUCASIAN
____AFRICAN AMERICAN	____UNKNOWN
____MORE THAN ONE RACE	____REFUSE TO REPORT

PATIENT NAME: _____

PATIENT (OR GUARDIAN) SIGNATURE:_____

DATE: _____

MALCOLM R. ING, M.D., INC.
KAPIOLANI MEDICAL CENTER
1319 Punahou Street, Suite 1110
Honolulu, Hawaii 96826 - 1032

(808) 955-5951 Office

OPHTHALMOLOGY

NON-COVERED SERVICES CONSENT FORM

I, _____,
understand that the services and/or supplies listed below may not be considered eligible for benefits (e.g., services and/or supplies may be determined to be not medically necessary, non-covered or investigational) by _____ (health insurer).

I understand that my health insurance coverage has certain restrictions and limitations, such as authorization requirements, and non-covered services and/or supplies. Since I have chosen to obtain the services and/or supplies listed below, I agree to be financially responsible for any and all related charges, if they are not covered by my insurance.

92002 - 99244

Services/Supplies Requested

Condition/Diagnosis

$52.36 - $397.91 — & all future visits

Approximate Cost of Service — Date of Service

Patient or Legal Guardian Signature — Date

Witness Signature — Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION FOR

MALCOLM R. ING, M.D.

I have read the notice of the Uses and Disclosures of Protected Health Information (the "notice") that is posted in your office. I was informed that I might also obtain a printed copy of the Notice from your receptionist. I hereby acknowledge that I received from **Malcolm R. Ing, M.D.** a copy of the notice.

_____

Print your name

_____

Name of patient if minor

_____

Signature

Date:_____

Malcolm R. Ing, M.D.
1319 Punahou Street, Suite 1110
Honolulu, HI 96826
955-5951

ABOUT OUR PAYMENT POLICY AND INSURANCE PARTICIPATION

Welcome to the office of Dr. Malcolm R. Ing. We are committed to providing you and your children with the best possible care in all aspects of our practice. If you have any medical insurance, we are anxious to help you receive your maximum allowable benefits. In order for us to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for services not covered by participating insurance and co pays are due at the time services are rendered. This will help in cutting down billing and mailing costs to both our practice and to you. We participate with several different insurance companies. Please check with the receptionist to see if the insurance policy you carry is one we participate with. Depending on your insurance plan, your payment or co-payment will be due at the time of service. We accept several forms of payment, including cash, personal checks and credit cards. Occasionally, we do make other payment arrangements, but the account's manager or the physician must approve these special arrangements in advance. We will be happy to help you process your insurance forms for your reimbursement. A completed insurance claim form for processing must accompany any such request. If you are with an insurance company that we do not participate with, in special instances, we may accept assignment of insurance benefits.

The will be a service charge for all returned checks. **Balances older than 60 days will be subject to a 1% billing charge. Charges may also be made for any missed appointments.**

Please feel free to ask our staff any questions you may have relating to your medical insurance coverage. **Please check and know your insurance plan benefits.** If you do not have a copy of your plan benefits, ask your employer or even your insurance company for a copy.

Please realize, however, that:

1. Your medical insurance is a contract between you and your insurance company and not with us.
2. Our fees are considered to fall within the acceptable range by most insurance companies and therefore should be covered up to the maximum allowance as determined by your coverage.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they **will not cover.**

We would like to emphasize again that as medical care providers, our relationship is with you and not with your insurance company. The filing of insurance claims is a courtesy we extent to our patients, **but all charges are your responsibility from the date the services are rendered.** We realize that temporary financial problems may affect timely payment of your account, and if such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions regarding our office financial policy, please do not hesitate to ask.

Malcolm R. Ing, M.D.

NOTICE OF THE USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by federal law to maintain the privacy of your Protected Health Information, and to provide you with notice of our legal duties and privacy practices regarding Protected Health Information. "Protected Health Information" is information that we keep in electronic, paper or other form, including demographic information collected from you and is created or received by us and relates to your past, present, or future physical or mental health or condition, the provision of health care services to you, or the past, present, or future payment for the health care services we deliver to you, and that identifies you or which we reasonably believe can be used to identify you.

We are required by federal law to comply with the terms of this Notice. We reserve the right to make changes in our privacy practices regarding your Protected Health Information. If we change our privacy practices, that change will apply to all Protected Health Information that we maintain about you. However, before we change our privacy practices, we will provide you with written notice of any changes.

We may use and disclose your Protected Health Information for a variety of purposes. For example:

1. Treatment: We may disclose your Protected Health Information to another physician, such as a specialist, to whom we refer you for medical treatment.

2. Health Care Operations: We may disclose your Protected Health Information to a health plan, managed care plan, individual practice association or to a management services organization that analyzes our delivery of medical services to evaluate our health care quality management, case management or professional competence. We may also provide your Protected Health Information to other health care providers, such as laboratories or ambulance companies, for purposes of their health care operations.

3. Payment: We may disclose your Protected Health Information to obtain payments. Disclosures for "payment" include: (a) disclosure to a health plan to determine your eligibility or coverage under the plan; (b) disclosures to a health plan to obtain reimbursement for delivering medical services to you; (c) disclosures to billing services or collection agencies; (d) disclosures for utilization management and determinations of whether the medical services we deliver to you are necessary or appropriate; or (e) disclosures to determine whether the amount we charge you for medical services are justifiable.

4. Reminders and Treatment Alternatives: We may contact you to provide you with appointment reminders or information about medical treatment alternatives or other health-related benefits and services that may be of interest to you.

We may use or disclose your Protected Health Information in connection with treatment, payment, or

health care operations if we deliver health care products or services to you based on the orders of another health care provider, and we report the diagnosis or results associated with the health care services directly to another health care provider, who provides the products or reports to you. We may use or disclose your Protected Health Information that was created or received in emergency treatment situations, to carry out treatment, payment, or health care operations if we attempt to obtain your consent as soon as reasonably practicable after the delivery of such treatment.

We may disclose your Protected Health Information without your authorization in the following circumstances: (a) for public health activities, such as controlling communicable diseases, reporting child abuse or neglect, to monitor or evaluate the quality, safety or effectiveness of FDA-related products or services; (b) for reporting victims of abuse, neglect or domestic violence; (c) for health oversight activities, such as overseeing government benefit programs; (d) in response to judicial or administrative orders, such as subpoenas; (e) for law enforcement purposes, such as mandatory reporting of certain types of wounds, or identifying or locating individuals; (f) for certain research purposes; (g) to avert a serious threat to the health or safety of an individual or the general public; and (h) for selected governmental functions, such as national security. In each of these situations we will keep records that explain our attempt to obtain your consent and the reason why consent was not obtained.

We are required to disclose your Protected Health Information: (a) to you upon your request; and (b) to the U.S. Department of Health and Human Services ("DHHS") when DHHS investigates to determine whether we are complying with federal law.

We may disclose your name, your location in our facility, your general condition and your religious affiliation, if any, in our facilities directory, unless you object verbally or in writing.

In all other circumstances we must obtain your authorization to use or disclose your Protected Health Information. You will be required to sign an authorization form which permits us to use and disclose your Protected Health Information for certain purposes, and we may not condition the delivery of medical treatment to you on your providing the requested written authorization. You have the right to revoke your authorization in writing as long as we have not acted in reliance on the authorization.

You have the following rights with respect to your Protected Health Information:

1. The right to request restrictions on our use and disclosure of your Protected Health Information for treatment, payment or health care operations. If we agree to any restriction, then we cannot violate that restriction except in the case of emergency treatment. However, we are not required to agree to any restrictions.

2. The right to request in writing and to receive confidential communications of your Protected Health Information by alternative means (such as by mail or email) or at alternative locations (such as your office or business workplace).

3. The right to request in writing access to our office to inspect and copy your Protected Health Information. Except in cases where the Protected Health Information is not maintained or accessible on-site, we will act on a request for access no later than thirty (30) days after we receive your request.

4. The right to request in writing that we amend your Protected Health Information. Your request must contain the reasons to support the requested amendment. We will act upon your request within sixty (60) days after we receive your request.

5. The right to receive an accounting of all our disclosures of your Protected Health Information in the six years prior to the date of your request, except for disclosures: (a) to carry out treatment,

payment and health care operations; (b) to you; (c) for our directory or to persons involved in your care; (d) for national security or intelligence purposes; (e) to correctional institutions or law enforcement officials; (f) pursuant to any written authorization that you give to us; or (g) that occurred prior to April 14, 2003.

6. The right to request and obtain from us a paper copy of this Notice.

If you believe that we have violated your privacy rights, then you may file a written complaint with Insert Name of Privacy Officer, who is our privacy officer. You may also file a complaint with the Office for Civil Rights of the DHHS. Your complaint must: (a) be in writing, either on paper or electronically; (b) name the Company and describe the acts or omissions you believed to be in violation of the Privacy Rules; (c) be filed within 180 days of when you knew or should have known that the act or omission complained of occurred, unless the time limit is waived by the DHHS for good cause shown. The complaint may be sent to: Office of Civil Rights, U.S. Department of Health and Human Services, Region IX, 50 United Nations Plaza, Room 322, San Francisco, CA 94102. We will not retaliate against you for filing a complaint. If you wish to obtain additional information about any of the matters discussed in this notice you may contact Insert Name of Privacy Officer at 955-5951.

This Notice is effective as of April 13, 2003.