Hana Holistic
MEDICAL CENTER

PATIENT REGISTRATION

DEMOGRAPHIC INFORMATION

LAST NAME: _____ FIRST NAME: _____ MI: _____

DATE OF BIRTH: _____ (mm/dd/yyyy) SEX: _____ RACE: _____

SOCIAL SECURITY #: _____ ETHNICITY: _____

ADDRESS 1: _____ ADDRESS 2: _____

CITY: _____ STATE: _____ ZIP: _____

LANGUAGE: _____ LANGUAGE COUNTRY: _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ PARTNER ☐ DIVORCED ☐ WIDOWED

☐ PREGNANT (check if applicable) ☐ NURSING (check if applicable)

Whom may we thank for referring you to our practice? _____

CONTACT INFORMATION

HOME PHONE: _____ WORK PHONE: _____ EXT: _____

CELL PHONE: _____ EMAIL: _____

EMERGENCY CONTACT INFORMATION

CONTACT FIRST NAME: _____ CONTACT LAST NAME: _____

CONTACT HOME PHONE: _____ CONTACT CELL PHONE: _____

RELATIONSHIP TO PATIENT: _____ CONTACT ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

FAMILY MEMBERS IN THE PRACTICE

_____ (name) _____ (relationship to patient)

_____ (name) _____ (relationship to patient)

_____ (name) _____ (relationship to patient)

_____ (name) _____ (relationship to patient)

PRIMARY CARE / OTHER PHYSICIAN

PHYSICIAN NAME: _____ PRACTICE NAME: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHARMACY NAME: _____ PHARMACY PHONE: _____

PHARMACY LOCATION: _____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ **Date:** _____

Hana Holistic Medical Center
2107 Channing Way, Berkeley, CA 94704
Office 510-527-1678 | Fax 510-527-1848

Hana Holistic
MEDICAL CENTER

INSURANCE INFORMATION

PRIMARY INSURANCE

INSURANCE COMPANY: _____ CO-PAY: _____

GROUP #: _____ SUBSCRIBER #: _____

INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____

SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____ EXT: _____

ADVANCED DIRECTIVE? ☐ YES ☐ NO WHERE IS IT FILED? _____(what medical facility?)

INSURED EMPLOYED BY: _____ BUSINESS ADDRESS: _____

CITY: _____ STATE _____ ZIP: _____ BUSINESS PHONE #: _____

ADDITIONAL INSURANCE

IS THE PATIENT COVERED BY ADDITIONAL INSURANCE? ☐ YES ☐ NO

INSURANCE COMPANY: _____ CO-PAY: _____

GROUP #: _____ SUBSCRIBER #: _____

INSURED FIRST NAME: _____ LAST NAME: _____ MI: _____

SOCIAL SECURITY #: _____ DOB: _____ RELATION TO PATIENT: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

PHONE #: _____ EXT: _____

INSURED EMPLOYED BY: _____

BUSINESS ADDRESS: _____ CITY: _____ STATE _____ ZIP: _____

BUSINESS PHONE # : _____

EMPLOYMENT STATUS: ☐ Employed ☐ Unemployed ☐ Full Time Student ☐ Part Time Student ☐ Retired

LAST DEGREE EARNED: ☐ HIGH SCHOOL ☐ COLLEGE ☐ GRADUATE SCHOOL

OCCUPATION: _____ BUSINESS NAME: _____

BUSINESS PHONE: _____

DRIVERS LICENSE #: _____ STATE ISSUED: _____

IS THIS AN ACCIDENT? ☐ YES ☐ NO

DATE OF INJURY _____

IS THIS A MOTOR VEHICLE ACCIDENT? ☐ YES ☐ NO

YOUR INSURANCE CARD AND PHOTO ID ARE REQUIRED AT THE TIME OF YOUR VISIT

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ **Date:** _____

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PATIENT REGISTRATION

Authorization to release or use information for treatment, payment, or health care operations

I hereby authorize the release or use of my individually identifiable health information (protected health information or PHI) and medical information by _____ in order to carry out treatment, payment, or health care operations. You should review the Practice's Notice of Privacy Practices for a more complete description of the potential release and use of such information, and you have the right to review such Notice prior to signing this Consent Form.

We reserve the right to change the terms of its Notice of Privacy Practices at any time. If we do make changes to the terms of its Notice of Privacy Practices, you may obtain a copy of the revised notice by writing our practice or requesting a copy from our front desk staff.

You retain the right to request that we further restrict how your protected health information is released or used to carry out treatment, payment, or heath care operations. Our practice is not required to agree to such requested restrictions; however, if we do agree to your requested restriction(s), such restrictions are then binding on the Practice.

I agree and consent to _____ releasing information to me in the following manners:

	PLEASE INITIAL
VIA MAIL	
☐ OK TO MAIL TO HOME ADDRESS	_____
☐ OK TO MAIL TO WORK ADDRESS	_____
VIA HOME TELEPHONE	
☐ OK TO LEAVE DETAILED MESSAGE	_____
☐ LEAVE CALL BACK NUMBER ONLY	_____
VIA WORK TELEPHONE	
☐ OK TO LEAVE DETAILED MESSAGE	_____
☐ LEAVE CALL BACK NUMBER ONLY	_____
VIA FAX	
☐ OK TO FAX TO: _____	_____

By signing below, I attest that the information provided above is true and accurate

Signature of Insured / Guardian: _____ **Date:** _____

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Hana Holistic
MEDICAL CENTER

Office Policies

Thank you for choosing the "Hana Holistic Medical Center" for your health care. Our office aims to provide you excellent medical care and customer service. We have implemented policies that will assist us to achieve our goals that we would like to bring to your attention:

1-**New patients please arrive 15 minutes before your appointment time. You must have a valid insurance card and current identification at the time of the first visit.**

2- **Insurance co-pays are due at the time of service:** Patients who do not pay their co-pay are billed a $15.00 service charge in addition to their co-pay. If you have an outstanding balance at the time of your appointment, payment will be expected. We accept cash, checks, and all major credit cards for your convenience. There is a $25.00 service charge for a returned check. Insurances are billed as a courtesy and the patient has financial responsibility for payment in full for services rendered.

3- **Insurance coverage and deductibles:** We recommend that you check with your insurance company whether we are listed under the network and what's your expected payment. We will collect a $175 deposit for each visit with high deductible plans. You will be refunded or billed for any difference after processing your claim.

4- **Appointment and Cancellation policy:** We recommend arrival 15 minutes prior to the visit. Late arrivals will be seen only upon the discretion of the provider. We request the courtesy of an advanced notification of 24 business hours for any appointment cancellation or reschedule. If you fail to notify us of your inability to keep your appointment, a "no-show" for your appointment time will be noted in your chart. After two consecutive no-shows, you may be considered for discharge from the practice. All patients who fail to present for their visits or cancel within 24 hours of their appointment will be subject for a fee of $50.00 for the first visit and $25.00 for a follow-up visit.

5-**Prescription refills:** New prescriptions and prescription changes are available to you during your visit. Refill requests should be made to your pharmacy. Please do not wait until you are out of medication to request a refill and allow 72 hours for prescription refills.

6- **Lab copies:** Most of the time, your labs will be available to be seen through the patient portal online. Paper copies of your labs can be requested during your visit as well.

7- **Medical records:** If another practitioner is requesting your records, they can be sent electronically, faxed, or mailed at no charge after you sign a medical release. Otherwise, to obtain a copy of medical records a fee of 10 cents per page and $6.00 per 15 minutes of processing fee is paid on request and may take up to two weeks. The records can be picked up at the office. Upon request they may be mailed Certified/Return Receipt for an additional cost of the mailing fee.

8-**Online Communication:** As a courtesy to our patients, we respond to your requests online through the patient portal. We recommend that the online communication be brief and limited to simple questions and answers. Please allow 24 - 48 hours for a response from our office. For urgent matters, we recommend that you call our office.

9. **Phone visits:** Communication with the physician through the portal is provided as a courtesy to our patients. Follow up visits on the phone upon the discretion of the provider.

10. **After-hour phone calls:** We are happy to answer the phone during our regular business hours, which is Monday to Friday, 8:30 am till 5:30 pm and we are closed for lunch between 12:30 pm and 1:30 pm. If you call our office after 5:30 pm or over the weekend, we advise that you leave a message and we will respond to you the next business day. If you have a matter that requires urgent medical attention, we advise that you visit the nearest Emergency Room.

I read the office policies for Hana Holistic Medical Center and I agree to all of them

Name _____ Signature _____

Hana Holistic
MEDICAL CENTER

Please read carefully, initial next to each statement and sign the form.

Consents:

1. _____ I have read and received a copy of this practice's Notice of Privacy Practices and the office policies.

Consent to release medical information

2. _____ I give consent to release medical information to the following parties: Third party payors covering the medical services, other health care professionals, institutions involved in my care, the proponent of any legally sufficient subpoena, or in response to a court order, employees and agents of the practice, pharmacies and other parties as otherwise required by law.

Consent to use SureScripts

3. _____I authorize "Hana Holistic Medical Center" to use SureScripts, Inc. a prescription system that allows prescriptions and related information to be exchanged between my providers and the pharmacy.

Assignment of Benefits

4. _____I hereby assign all medical benefits, including major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), to issue payment check(s) directly to " Hana Holistic Medical Center" for the medical services rendered to myself.

Consent to treat

5. _____ I give permission for "Hana Holistic Medical Center " to give me medical treatment. I understand that I have the right to discuss all medical treatments with my provider and to refuse any procedure or treatment.

Releasing medical information to friends and family

6. _____ I hereby give authorization to release information and/or discuss my medical condition including my protected health information with the person(s)/entities listed below:

Person/entity name: _____Phone # _____

Relationship to Patient _____

This authorization can be revoked at any time upon my request in writing.

Patient's Signature: _____Date: _____

Print Full Name:_____

_____

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AUTHORIZATION FOR USE AND/OR DISCLOSURE OF PATIENT HEALTH INFORMATION

I understand that *Hana Holistic Medical Center* (name of clinic) will not condition treatment, payment, enrollment, or eligibility for benefits on my providing or refusing to provide this authorization.

I hereby authorize _____
NAME OF DISCLOSING PARTY { PREVIOUS PHYSICIAN}

_____
ADDRESS

_____
PHONE NUMBER FAX NUMBER

to disclose to *Hana Holistic Medical Center*
NAME OF RECEIVING PARTY

2107 Channing Way, Berkeley, CA 94704
ADRESS

Records and information pertaining to

_____ _____ _____
PATIENT NAME (list other names used) MEDICAL RECORD # DATE OF BIRTH

_____ _____
ADRESS TELEPHONE #

DURATION: This authorization shall become effective immediately and shall remain in effect for 6 months from the date below.

REVOCATION: This authorization is also subject to written revocation by the patient /guardian at any time. The written revocation will be effective upon receipt, except to the extent that the disclosing party or other have acted in reliance upon this authorization.

REDISCLOSURE: I understand that the receipt may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specially required or permitted by law.

SPECIFY RECORDS: Check the box and initial to specify which type of information that is to be disclosed.

- ☐ **MEDICAL INFORMATION** _____ INITIAL
- ☐ **PSYCHIATRIC INFORMATION** _____ SIGNATURE
- ☐ **DRUG/ALCOHOL INFORMATION** _____ SIGNATURE
- ☐ **RESULTS OF AN HIV BLOOD TEST** _____ SIGNATURE
- ☐ **OTHER HEALTH INFORMATION** (Specify below) _____ INITIAL

Specify the records to be disclosed: _____

_____

The receipt may use the health information authorization on this form for the following purposes: _____

_____

Signature: _____ Date: _____

If signed by other than patient, indicate relationship: _____

HANA HOLISTIC MEDICAL CENTER

MEMBERSHIP AGREEMENT FOR PATIENT-CENTERED HOLISTIC MEDICINE SERVICES

Please print:

Member Name: _____ ("Member")

Mailing Address: _____

Email: _____

Primary phone number: _____ Secondary phone number: _____

Date: _____ ("Effective Date") **Member signature required on last page*

THIS MEMBERSHIP AGREEMENT FOR PCHM SERVICES ("Agreement") is effective as of the Effective Date written above, by and between HANA HOLISTIC MEDICAL CENTER, a California medical service ("Provider") and the Member identified above, with reference to the following facts:

WHEREAS, the Patient identified above desires unique services and benefits to be provided by Physician that are not covered or otherwise not reimbursable under a private health insurance policy, private health plan or government program, including, but not limited to, Medicare, in which Patient is enrolled;

WHEREAS, the Physician identified below desires to provide such unique services and benefits to Patient for which Physician cannot, and will not, seek reimbursement under a private health insurance policy, private health plan or government program, including, but not limited to, Medicare, in which Patient is enrolled;

WHEREFORE, by signing this Patient Enrollment Agreement, Patient and Physician hereby agree, effective on the date signed by Physician, for valuable consideration, to enter into a contractual relationship for the provision of specified services and benefits under the following terms and conditions.

A. BENEFITS AND SERVICES

Hana Holistic Medical Center (HHMC) agrees to provide to Patient the following Benefits and Services:

- 10% off acupuncture sessions (not covered by Medicare or insurance);
- 3 free classes, and 5% off weekend workshops at HHMC; and
- Access to signing up for membership in classes through HHMC information system.

Classes and workshops my include the following which are provided for a fee subject to above mentioned discounts:

- Yoga classes;
- Group fitness;
- Dance therapy;
- Tai Chi;
- Chi Gong;
- Energy movement exercises;
- NIA dance;
- Acupressure;
- Energy healing; and
- Massage therapy.

HHMC's goal will be to nurture and support the patient's personal transformation to a healthy wellness-based lifestyle. In keeping the classes in small groups, HHMC visitors will receive a more personal connection with the teachers.

HHMC will provide educational workshops which with the goal of enhancing the knowledge and art of healing the body, mind and spirit. These workshops may include lectures and courses about Chinese medicine, acupuncture, healthy eating, herbology, bodywork. and mindfulness-based stress reduction.

As a member of Hana Holistic Medical Center you will have the advantage of our premium MediTouch patient portal where you can have:

- Priority email to your doctor
- Secure, online access to your personal health record
- Time saving tools such as easy registration and appointment scheduling as well as request for video visits.
- Access to your lab results and ability to request medication refills online.

B. PREMIUM

Patient agrees to pay to Physician an ANNUAL Enrollment Fee of $400 or $35 MOTHLY as valuable consideration for the provision of Benefits and Services or

100 patients will have an option to become "Vision Supporters" of the center for a MONTHLY membership of $199 for unlimited free classes, 10% off weekend workshops and 20% off acupuncture sessions (not covered by Medicare or insurance).

C. PATIENT ACKNOWLEDGMENTS AND CONDITIONS OF PARTICIPATION

Patient acknowledges and understands that Benefits and Services are unique and provided with certain specific limitations and conditions, as follows:

1. Benefits and Services are not covered and otherwise not reimbursable under any private health insurance policy, private health plan or government program,

including, but not limited to, Medicare, in which Patient is enrolled. Accordingly, Patient understands and acknowledges that Benefits and Services convey value and benefits that Patient does not already receive under any private health insurance policy, private health plan or government program, including, but not limited to, Medicare, in which Patient is enrolled. To the extent any one or more Benefits and Services are considered covered and reimbursable benefits, the Enrollment Fee is consideration for the remaining items of Benefits and Services.

2. The list of Benefits and Services may be amended or modified to the extent necessary to reflect any change in interpretation or terms of coverage and benefits of any private health insurance policy, private health plan or government program, including, but not limited to, Medicare, in which Patient is enrolled.

3. For Benefits and Services provided herein, Patient and/or Physician cannot, and will not, bill to or seek reimbursement from any private health insurance policy, private health plan or government program, including, but not limited to, Medicare, in which Patient is enrolled.

4. Physician may also provide service(s) to Patient that are covered or reimbursable from a private health insurance policy, private health plan or government program, including, but not limited to, Medicare, in which Patient is enrolled. In such case, Physician may bill and seek reimbursement from Patient's private health insurance policy, private health plan and/or Medicare under the terms and conditions of Patient's enrollment agreement with such payor(s). Physician may also seek reimbursement from Patient as permitted under Patient's enrollment agreement with such payor(s) (e.g., deductibles, coinsurance or copays). Patient understands and acknowledges that any covered and reimbursable services are separate and distinct from and independent of the Benefits and Services provided herein.

5. This Agreement can be terminated by providing a notice to the Medical Center of at least 45 days. We believe the 45 days is necessary to allow the Medical Center to make every effort to accomplish your health goals.

IN WITNESS WHEREOF, the parties have executed this Membership Agreement for PCHM Services effective as of the date first written above.

MEMBER:

Signature: _____ Signature: _____

Print Name: _____ Print Name: _____

PROVIDER:
HANA HOLISTIC MEDICAL CENTER

By: _____ Date: _____
Anas Hana, M.D., President