JOSEPH RYAN M. MADAMBA, M.D.
INTERNAL MEDICINE & INTEGRATIVE MEDICINE
1712 Liliha St. Suite 203
Honolulu, HI 96817
Office (808) 523-7955 Fax (808) 536-9498

Today's Date:_____

REGISTRATION FORM

(Please print legibly)

PATIENT INFORMATION

At every visit please bring all updated insurance cards and photo ID. All information is kept strictly confidential.

Last name:	First:	Middle:	Title:		Marital status:	
Preferred nickname (if any):			Suffix:		Single ☐ Mar ☐ Div ☐ Sep ☐ Widow ☐	
Place of birth:	DOB: / /	Height:	Weight:	Age:	Sex: ☐ M ☐ F	Social Security #:
Street address:		Home phone: ( )			Cell phone: ( )	
City:	State:	Zip code:	E-mail:			
Occupation(s):	Employer(s):	Work schedule:	Work phone: ( )			
Ethnicity(ies):		Referred by:				
Who lives at home with you?		Person who is financially responsible (if not the patient or if patient is a minor):				

INSURANCE INFORMATION

Primary insurance:		Policy #:	Group #:	
Subscriber's name:	Subscriber's DOB:	Subscriber's SSN:	Co-pay:	
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other
Secondary insurance (if applicable):		Policy #:	Group #:	
Subscriber's name:	Subscriber's DOB:	Subscriber's SSN:	Co-pay:	
Patient's relationship to subscriber:	☐ Self	☐ Spouse	☐ Child	☐ Other
Medicare # (if any):		Medicaid # (if any):		

IN CASE OF EMERGENCY

Emergency contacts: 1. 2.	Relationship to patient:	Primary phone : ( ) ( )	Secondary phone: ( ) ( )

The above information is complete, true, and accurate to the best of my knowledge.

Patient / Guardian signature *Date*

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Patient Financial Responsibilities and Practice Policies

Our goal is to provide each patient with the finest medical care in a professional environment, which inspires trust and confidence. Our medical office is a business that must be managed efficiently if we are to continue serving the community with quality primary care services. Our fees are fair and reflect the care and expertise with which we treat each patient. The following outline of financial responsibilities and practice policies have been established to assist us in providing the highest quality of medical care.

Insurance: It is your responsibility to know and understand your coverage and benefits. Our billing associate, Catherine Kelly, files your insurance forms. It is important to make sure that your insurance and demographic information is kept up to date with our office. This includes any change of information such as address, phone numbers, and insurance changes. If the patient is not the policy holder on the insurance, we require the policy holder's full name, date of birth, social security number, employer information (if applicable), and relationship to the patient to file all claims. Co-payments are due in full at the time services are rendered. Patients are responsible for all fees that are not covered by insurance, including co-payments, coinsurance, deductibles and non-covered services or items received. At every visit, please make sure you have all insurance cards and photo identification as well as any other documents (such as authorization/referrals) that may assist us in processing your insurance forms correctly.

No Insurance: If you are not covered by insurance at the time of service, please be advised that you will be responsible for all charges incurred at the time of service. In these cases, fees depend on the complexity of the problems addressed during the visit. Cash, check, or credit card is accepted.

Returned Checks: There will be $35 charge assessed for any check returned by your bank for any reason.

Collections: All billing inquiries and collections are coordinated and handled by our business associate, Catherine Kelly. Our practice offer a flexible payment plan and financial assistance options. Accounts that are not settled in a timely fashion may be sent to a collection agency and the patient responsible for collection expenses. If acceptable terms cannot be reached to satisfy the past due balance, the patient may be dismissed from our practice.

Medical Records: We will provide a copy or disc of your *complete* medical records upon request for $25 administrative plus $1.00 per page thereafter. You will be required to sign a medical record release form and pay the medical record fee in full prior to having your medical records printed/copied. Please allow up to 2 weeks for this request to be processed. Upon request, we will provide a copy of *limited portions* of a medical record (e.g. most recent labs or note) within 2 weeks upon verbal or written request for a cost of $1.00 per page.

Hospital Admissions: Dr. Joseph Madamba does not admit patients to any hospital. However, he will assist in providing information and helping coordinate care with the hospitalist service in the event you are admitted to a hospital.

Dismissal Process: There are several reasons that a patient may be dismissed from our practice. A few reasons (though not all) are as follows:

- Failure to keep scheduled appointments and regular follow-up
- Failure to return medically-important phone calls or messages
- Being rude or abusive to staff, including verbally or physically
- Deceptive or criminal behavior (e.g. lying about medical history, selling prescriptions, forging prescriptions or notes from the doctor)
- Repeated failure to follow medical advice and treatment
- Failure to meet financial obligations

In this case, a certified letter will be sent to your last known address notifying you that you are being dismissed from our practice. If you have a medical emergency within 30 days of the date of the letter, Dr. Madamba will help coordinate your care. After the 30 day period, you will no longer be seen by Dr. Madamba as a patient. A copy of your medical record may be forwarded to your new health care provider after a formal request is made and appropriate fees are paid.

Patient Acknowledgement:

I have read, fully comprehend, and agree to all of the above **Patient Financial Responsibilities and Practice Policies**.

_____

Print Patient Name

_____

Patient/Guardian Signature *Date*

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Notice of Privacy Practices Acknowledgement

I understand that as part of my healthcare this practice originates and maintains health records describing my personal information (PHI) including health history, symptoms, examinations, tests results, diagnoses, treatments, and any plans for future care or treatment. I understand that, under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights to privacy regarding my health information and that this information will be used to:

- Conduct, plan, and direct my treatment and follow-up among the many health professionals who may be involved in my care directly and indirectly
- Obtain payment from third-party payers (insurance carriers, etc.); for example, by applying my diagnosis and procedural information to my bill, or by allowing third-party payers to verify that services billed were actually provided
- Conduct normal healthcare operations; for example, assessing quality and reviewing the competence of healthcare professionals, or contacting me or leaving me a message via phone, mail, or e-mail to discuss appointment reminders, insurance or billing items, or items relating to my clinical care

In addition to the above, we may use and disclose your PHI without your consent or authorization for the following reasons:

- When a disclosure is required by federal, state or local law, judicial or administrative proceedings or law enforcement
- For public health activities; for example, providing information about births, deaths, and certain diseases such as tuberculosis
- For health oversight activities; for example, providing information to assist the government in conducting an investigation or inspection of a health care provider or organization
- To avoid harm or a threat to the health or safety of a person or the public; for example, by providing PHI to government or law enforcement personnel or persons able to prevent or lessen such harm
- For workers compensation purposes
- Disclosures to family, friends, or others – if applicable, the following persons have permission to discuss your medical information:

_____

I understand and know that, upon request, I have access to Joseph Ryan Madamba, M.D., Inc's Notice of Privacy Practices that provides a more complete description of my health information uses and disclosures. I understand that Joseph Ryan Madamba, M.D., Inc. reserves the right to change its notice and practices and, prior to implementation, will post a copy of any revised notice. I understand that I have a right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Joseph Ryan Madamba, M.D., Inc. is not required to agree to the restrictions requested.

I hereby give my consent for Joseph Ryan Madamba, M.D., Inc. to use and disclose my personal health information to carry out all of the above mentioned healthcare operations. If I do not sign, or later revoke this consent, Joseph Ryan Madamba, M.D., Inc. then I may be dismissed by the practice.

_____
Print Patient Name

_____ _____
Patient/Guardian Signature *Date*

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Photographic Informed Consent

I am aware that any photos being taken of me are for identification, diagnostic, documentation, and educational purposes only. I hereby grant these photos to be taken. I understand that when my photos are being used for these purposes, my face (if applicable) will be concealed and my name will be withheld.

Print Patient Name

Patient/Guardian Signature *Date*

Print Witness Name

Witness Signature *Date*

Comprehensive Health History

Name: _____ Date:_____

Health Care Providers

(List all other doctors, therapists, and practitioners who saw you in the last 10 years)

Name	Specialty/Occupation	Location	Dates

Personal Medical History

(List and/or check all that apply, include dates)

Past/Present Medical Conditions	Surgeries/Procedures	Hospitalizations
		Gave blood before?: Y / N

☐	Anemia	☐	Emphysema/Chronic Bronchitis	☐	Kidney Stones
☐	Anxiety	☐	Epilepsy/Seizures	☐	Liver Disease, type:
☐	Asthma	☐	Gallstones	☐	Prostate Problem:
☐	Bleeding from Bowels	☐	Glaucoma	☐	Sexually Transmitted Infections
☐	Bleeding Problems, type:	☐	Gout	☐	Skin Disease, type:
☐	Blood Clot in Leg	☐	Heart Attack	☐	Stroke
☐	Blood Clot in Lung	☐	Heart Murmur	☐	Thyroid Problem, type)
☐	Blood Transfusion	☐	High Blood Pressure/Hypertension	☐	Tuberculosis
☐	Cancer, type:	☐	High Cholesterol	☐	Ulcers in Stomach/Bowels
☐	Congestive Heart Failure	☐	Irregular Heart Beat	☐	Other:
☐	Depression	☐	Joint Disease/Arthritis, type:	☐	Other:
☐	Diabetes/High Blood Sugar	☐	Kidney Disease, type:	☐	Other:

Medications

(List names and doses of all medications, vitamins/supplements, herbs, and complementary/alternative therapies)

	Are you interested in learning about complementary/alternative treatments? Y / N

Allergies (and what kind of reaction?):

Health Maintenance Items

(Enter most recent date for each, and any abnormal results)

Vaccines	Women's Health		Men's Health
Flu:	Mammogram:		PSA test:
Pneumonia:	Breast exam:		Prostate exam:
Hepatitis A:	Pap smear/Pelvic exam:	# Pregnancies: # Deliveries:	Testicular exam:
Hepatitis B:	Last menstrual period: Was it normal/regular? Y / N	Forms of birth control and/or protection (if sexually active):	
Tetanus-Diphtheria-Pertussis (TDaP):	Bone density test (DEXA scan):		
Shingles: Have you had chickenpox before? Y / N	**General Health**		
	Colonoscopy:	Vision test:	Hearing test:
Other vaccines:	Cholesterol/Triglycerides testing:	Dental checkup:	
	Blood sugar testing:	STD testing:	
	Depression screening:	Safety screen (seat belt use, any abuse/violence, firearms, smoke detector use):	

Family History

(Medical conditions in parents/siblings/grandparents/children/other relatives)

☐ Alcohol/Drug Addiction	☐ Glaucoma / Cataracts / Eye problems	☐ Osteoporosis/fracture
☐ Anxiety or Depression	☐ Heart Attack/Heart Disease	☐ Stroke
☐ Asthma/Lung Disease	☐ High Blood Pressure	☐ Thyroid Problem
☐ Bleeding Problems	☐ High Cholesterol	☐ Genetic Testing, for:
☐ Cancer, types:	☐ Kidney Disease, type:	☐ Other:
☐ Diabetes/High Blood Sugar	☐ Liver Disease, type:	Mother: Father: Siblings: Children:
☐ Epilepsy/Seizure	☐ Low Blood Count/Anemia:	

Lifestyle & Habits

Diet	Cups of water/day: Soda+juice/day: Veg servings/day: Fruit servings/day: Whole grains/day: Meat servings/day: I have a tendency towards these foods: Salty Sweet Fried/greasy Restaurants: Processed foods:		
Exercise	Types of exercise, how often and how much:		
Smoking	Packs per day:	# of years:	Quit (year):
Alcohol	Types of alcohol, how often and how much:	# of years:	
Drugs	Types of drugs:		# of years
Stress & Sleep	Average stress level from 0 (no stress) to 10 (highest stress): How do you handle stress: How much do you sleep each day:		

I certify that the information listed above is complete and accurate.

Patient Name *Patient/Guardian Signature* *Date*

JOSEPH RYAN M. MADAMBA, M.D.
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Authorization for Release of Medical Records

Date: _____

Patient Name: _____ Patient DOB:_____

Physician Name: _____Physician Fax:_____

I request and authorize my medical information and records concerning my history, treatment, examinations (including labs, imaging, and pathology reports), procedures, hospitalizations, or other specified information be sent to:

Joseph Madamba, M.D.
1712 Liliha St. Ste # 203
Honolulu, HI 96817
Fax: (808) 536-9498 (if more than 10 pages and non-urgent, please mail instead of fax)

If specific information requested only:_____

Patient/Guardian Signature: _____

Thank you for your kind consideration and prompt cooperation.

Sincerely,

Joseph Madamba, M. D.

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Credit Card/Debit Card Authorization

To Our Patients:

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill.

This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster and more efficient.

We have implemented a similar policy. You will be asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Copays due at the time of the visit will, of course, still be due at the time of the visit. You have the option of paying by cash, check or credit card at the time of the visit. If your copay is not paid at the time of your visit, it will be charged to your credit card.

If you have any questions about this payment method, do not hesitate to ask us.

Aloha,
Joseph Madamba, M.D.

Please fill out below:

Credit Card/Debit Card Type: _____ Visa _____ Mastercard _____ Amex _____ Other

_____ Visa Debit _____ Mastercard Debit

Name as it appears on the card: _____

Card Number: _____

Expiration Date: _____ / _____

I give authorization to bill my card for any balance due on my account:

_____ _____
Cardholder Signature Date

_____
Cardholder Name (if different from patient)

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No Show Policy

Our office has a no show policy that requires patients to ***cancel or reschedule 24 hrs during before their appointment*** in order to prevent a no show fee.

We understand patients and doctors alike may be running late or have to cancel/reschedule of a number of good reasons. Our office is almost always able to accommodate patients who are late. Likewise, we expect the same reasonable understanding from patients if the office is running late - as is known to happen in medical practices where we deal with real people and lives with complex medical issues.

However, in most cases simply not showing up for an appointment to our office (or for that matter, any other appointments/referrals we make for you) without any notification is unacceptable. That is common courtesy. In the same vein, our office would not move/cancel your appointment without notifying you first and without good reason. **Repetitive no show behavior is grounds for dismissal from the practice.**

In summary, you are responsible for keeping your scheduled appointments and arriving on time. If you arrive later than 10 minutes after your scheduled appointment, you may have to be rescheduled in order to accommodate patients that have arrived on time. If you are unable to keep your scheduled appointment, please call our office to cancel and/or reschedule as soon as is possible. ***There will be a $45 fee* for each missed appointment.*** In select cases, re-consideration may be given.

Mahalo for your understanding.

I agree to the above conditions:

_____ _____

Print Name Signature

_____

Date

*No show fee may change over time

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Physician-Patient
Clinical Roles & Responsibilities Agreement

Dear Patient,

Welcome and thank you for choosing me as your primary care doctor. I am committed to providing you with the best medical care tailored to your personalized health needs and goals. My staff and I will work as a team with you and your other health care providers to take care of you. I hope we can form a partnership to keep you as healthy as possible in mind, body, and spirit, no matter what your current state of health is. With your commitment, we can make this relationship work effectively for your health and our mutual satisfaction.

As your Primary Care Provider, I will strive to:

- Learn about you, your family, life situation, health goals and preferences. I will consider these and your health history every time you seek care and suggest treatments that are appropriate for you.
- Take care of any short-term illness, long-term chronic illness, and promote your all-around health and well-being.
- Connect you with other members of your care team (specialists, health coaches, etc.) and coordinate your care with them according to your health needs and preferences.
- Facilitate and coordinate your health care, as indicated and appropriate, even while you may not be present in the office for a visit.
- Communicate clearly with you so that you understand your health conditions and diagnostic & treatment options.
- Be available to you after hours for your urgent needs.
- Notify you of significant test results in a timely manner, usually in the setting of an office visit.
- Listen to your questions, concerns, and feelings and respond accordingly with professionalism, compassion, and in a way that is understandable.
- Help you make the best decisions for your care.
- Give you assistance with resources and services that can help you stay healthy and learn more about your health and health condition(s).
- Keep you up-to-date with preventive screening tests and other health maintenance items (e.g. vaccines)
- Continually reassess and work to improve all aspects of our practice's operations.

We trust you, as the Patient, will strive to:

- Be a proactive participant in your care, and recognize that you are a full partner with us in your care.
- Inform/remind us when you see other health care providers or go to other health care facilities (e.g. emergency rooms/hospitals, specialists, lab and imaging centers, complementary & alternative health) so we can obtain all updates/reports pertinent to your health care. We periodically update your list of all health care providers and each of them should receive all relevant information related to your health care.
- Pay your share of any fees in a timely manner.
- Come to each visit with any updates to your demographics and insurance coverage.

- Come to each visit with any updates to your health, medications, supplements, remedies, or other traditional or non-traditional treatments you're using. Please bring all your medicine/supplement bottles or a complete list of those to every visit.
- Come to each visit prepared to discuss your specific and prioritized questions and concerns.
- Keep scheduled appointments or call to reschedule or cancel as early as possible, if necessary.
- Come to the office to discuss any and all test results, unless stated otherwise, and also contact us if you do not receive your test results within two weeks.
- Learn about and understand your health condition(s) and treatment(s), and tell us when you don't understand something.
- Make an honest effort to live a healthy lifestyle to the best of your ability. Learn about what you can do to stay healthy as possible.
- Earnestly follow the plan that we have agreed is best for your health (e.g take medications, undergo tests, attend referrals, and follow treatments as prescribed.)
- Call at least 72 business hours ahead of time before medicines run out to request refills or lab requisitions are needed.
- Contact us after hours only if your issue cannot wait until the next business day.
- Learn about your health insurance coverage and contact your insurance carrier if you have questions about your benefits and coverage.
- Give us honest feedback to help us improve our care and operations.

As your Primary Care Provider, I look forward to working with you to help you meet your health goals and to help optimize your health.

Provider Signature	Printed Provider Name	Date

Patient Signature	Printed Patient Name	Date

Parent/Guardian Signature	Printed Parent/Guardian Name	Date

Cell Phone Number*: _____

E-mail Address*: _____

*By providing your cell phone number and/or email address, you consent to our office staff contacting you regarding your medical care via cell phone or email.

Joseph Ryan Madamba, M.D., Inc.
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Honolulu, HI 96817
Phone (808) 523-7955 Fax (808) 536-9498

Informed Consent for Telemedicine Services

PATIENT NAME: _____	TODAY'S DATE
EMAIL: _____	DATE OF BIRTH:
CELL PHONE: _____	
EMERGENCY CONTACT: _____	

Introduction

Telemedicine involves the use of electronic communication to enable health care providers improve the delivery of patient care. As an extension of my practice, I am offering select patients the option to use telemedicine for select, limited purposes. Telecommunication is not intended to replace face-to-face communication between physician and patient. The communication may be used for limited purposes such as follow-up care to an office visit and/or patient education, and may include but is not limited to the following:

- Patient-specific medical information
- Live two-way audio and video
- Medical images

www.Doxy.me telemedicine platform is an easy to use HIPAA-compliant platform that requires no downloads or installation. Patients will need a camera-ready cellphone, laptop, tablet, or desktop in order to participate in telemedicine. Your medical information will be encrypted to provide protection of and prevent unauthorized access to your confidential medical information; however, 100% confidentiality cannot be guaranteed. Dr. Madamba will include additional measures to safeguard the data and to ensure its integrity against intentional or unintentional consumption.

Expected Benefits:

- Improved access to Dr. Madamba's care and potentially patient outcome by enabling a patient to remain in his/her home (or at another location) while discussing test results and other clinical information with Dr. Joseph Madamba.
- Reduced need to return-to-office for follow-up care.

Possible Risks:

As with any communication method, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- An unexpected power outage or scheduling adjustments may delay a telemedicine appointment and may result in the patient having to come into the office.
- Many if not most medical problems require examination to thoroughly evaluate, which is not to perform possible via telemedicine.

Please initial after reading this page:_____

I have been offered a copy of this consent form (patient's initials) _____

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By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to any persons or entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that it is my duty to inform Dr. Madamba of electronic interactions regarding my care that I may have with other healthcare providers.
4. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

Patient Consent for the Use of Telemedicine via www.Doxy.me

I have read and understand the information provided above regarding telemedicine, have discussed it with Dr. Madamba and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I hereby authorize Joseph Madamba, MD to use telemedicine in the course of my diagnosis and treatment.

Patient Name: _____ Date: _____
Patient Signature: _____
Responsible party (if other than patient): _____
Witness: _____ Date: _____

Please initial after reading this page:_____

I have been offered a copy of this consent form (patient's initials) _____

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About Nutritional and Herbal Supplements

According to the Federal Food, Drug, and Cosmetic Act, as amended, Section 201(g)(1), the term *drug* is defined as an "article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease." Technically, vitamins, minerals, trace elements, amino acids, herbs, or homeopathic remedies are not classified as drugs. However, these substances can have significant effects on physiology and must be used rationally, weighing benefits and risks. In this office, we provide nutritional counseling and make individualized recommendations regarding use of these substances in order to upgrade the quality of foods in a patient's diet and to supply nutrition to support the physiological and biomechanical processes of the human body. Although these products may also be suggested with a specific therapeutic purpose in mind, their use is chiefly designed to support given aspects of metabolic function. Use of nutritional and herbal supplements may be safely recommended for patients already using pharmaceutical medications (drugs), but some potentially harmful interactions may occur. For this reason, it is important to keep all of your healthcare providers fully informed about all medications and nutritional supplements, herbs, or hormones you may be taking.

Sale of Nutritional Supplements at *Joseph Ryan Madamba MD Inc*

As a service to you, we make nutritional supplements available in our office. We purchase these professional-grade products only from manufacturers who have gained our confidence through considerable research and experience. We determine quality by considering: (1) the quality of science behind the product; (2) the quality of the ingredients themselves; (3) the quality of the manufacturing process; and (4) the synergism among product components. The brands of supplements that we carry in our facility are those that meet our high standards and tend to produce predictable results. ***You are under no obligation to purchase nutritional supplements at our clinic.***

While these supplements may come at a higher financial cost than those found on the shelves of pharmacies or health food stores, the value must also include assurance of their purity, quality, bioavailability (ability to be properly absorbed and utilized by the body), and effectiveness. The chief reason we make these products available is to ensure quality. You are not guaranteed the same level of quality when you purchase your supplements from the general marketplace. We are not suggesting that such products have no value; however, given the lack of stringent testing requirements for dietary supplements, product quality varies widely.

If you have concerns about this issue, please discuss them with our staff.

I, _____,

have read and understand the above statement on _____ (date),

witnessed by _____, _____ (date).