

Screening: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Age: \_\_\_\_\_

Have you traveled in the last month? Where?

Yes, \_\_\_\_\_

No

Are you experiencing any of these symptoms? Check all that apply.

Fever

Fatigue (Tiredness)

Cough

Shortness of Breath

Runny or Stuffy Nose

Vomiting

Sore Throat

Diarrhea

Loss of Taste or Smell

Any upper respiratory

Muscle or Body Aches

symptoms

Are you a healthcare worker , had contact with a healthcare worker , or had known contact with a positive COVID-19 persons ?

None of the above

**SIGN-IN SHEET**

Today's Date: \_\_\_\_\_

Name \_\_\_\_\_ Student ID: \_\_\_\_\_ Phone \_\_\_\_\_  
Last First

Date of BIRTH \_\_\_\_\_ AGE \_\_\_\_\_ Email \_\_\_\_\_

Do you have an appointment today?  YES  NO

COVID VACCINE: Dose 1 \_\_\_\_\_ Dose 2 \_\_\_\_\_

Last COVID Test: Date: \_\_\_\_\_ NEG or POS (circle one)

**I am Here for:** (check the boxes that apply)

- Annual  Consult  Plan B
- Birth Control/ Refill  Depo  Pregnancy Test
- STD testing  UTI  Dive PE
- Injury  Illness  Shots/TB \_\_\_\_\_
- Medication Refill: \_\_\_\_\_
- Other: \_\_\_\_\_
- Symptoms: \_\_\_\_\_

**Status**

- UH Hilo Student  Staff
- HawCC Student  Public
- Other \_\_\_\_\_

**Level**

- Freshman  Junior  Graduate Student
- Sophomore  Senior

**Sex**

- Male  Female

**Insurance**

- HMSA  PENDING
- Blue Cross  None/Uninsured
- Quest-HMSA  Other Insurance: \_\_\_\_\_
- Quest-AlohaCare \_\_\_\_\_
- Not Sure ????

-How many days have you been experiencing the above symptoms? \_\_\_\_\_

-Would you like to become pregnant in the next year? YES \_\_\_\_\_ NO \_\_\_\_\_

\*\*\*\*\***Travel Screening:** Please answer these two questions

Have you traveled in the last month? \_\_\_\_\_

Please list the places, countries: \_\_\_\_\_

**Depression Screening:**

Do you feel down, depressed, or hopeless? Yes \_\_\_ No \_\_\_

Do you have little interest or pleasure in doing things? Yes \_\_\_ No \_\_\_

----- (Do not write below this line)-----

**Diagnosis:** \_\_\_\_\_

\_\_\_\_\_ Meningococcal \_\_\_\_\_ HPV \_\_\_\_\_ Hepatitis A \_\_\_\_\_ Hepatitis B \_\_\_\_\_ MMR \_\_\_\_\_ Tdap

**The Patient Health Questionnaire-2 (PHQ-2)**

Patient Name: \_\_\_\_\_ Date of visit: \_\_\_\_\_

Over the past 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half the days	Nearly every day
3. Little interest or pleasure in doing things	0	1	2	3
4. Feeling down, depressed or hopeless	0	1	2	3

## TELEHEALTH INFORMED CONSENT

*Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up, and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, patient portals, and remote patient monitoring are all considered telehealth services.*

Patient's  
Initials

\_\_\_\_\_ I understand that telehealth involves the communication of my medical/mental health information in an electronic or technology-assisted format.

\_\_\_\_\_ I understand that I may opt out of the telehealth visit at any time. This will not change my ability to receive future care at this office.

\_\_\_\_\_ I understand that telehealth services can only be provided to patients, including myself, who are residing in the state of \_\_\_\_\_ at the time of this service.

\_\_\_\_\_ I understand that telehealth billing information is collected in the same manner as a regular office visit. My financial responsibility will be determined individually and governed by my insurance carrier(s), Medicare, or Medicaid, and it is my responsibility to check with my insurance plan to determine coverage.

\_\_\_\_\_ I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include but are not limited to:

- *It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.*
- *Electronic systems that are accessed by employers, friends, or others are not secure and should be avoided. It is important for me to use a secure network.*
- *Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.*

\_\_\_\_\_ I agree that information exchanged during my telehealth visit will be maintained by the doctors, other healthcare providers, and healthcare facilities involved in my care.

\_\_\_\_\_ I understand that medical information, including medical records, are governed by federal and state laws that apply to telehealth. This includes my right to access my own medical records (and copies of medical records).

\_\_\_\_\_ I understand that Skype, FaceTime, or a similar service may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed.

- \_\_\_\_\_ I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications by others.
- \_\_\_\_\_ The healthcare provider is not responsible for breaches of confidentiality caused by an independent third party or by me.
- \_\_\_\_\_ I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may terminate the telehealth visit.
- \_\_\_\_\_ I understand that I have a responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.
- \_\_\_\_\_ I understand that electronic communication cannot be used for emergencies or time-sensitive matters.
- \_\_\_\_\_ I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As the patient, I agree to accept responsibility for following my healthcare provider's recommendations—including further diagnostic testing, such as lab testing, a biopsy, or an in-office visit.
- \_\_\_\_\_ I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, or addiction treatment (alcohol, drug dependence, etc.).
- \_\_\_\_\_ I understand that my healthcare provider may choose to forward my information to an authorized third party. Therefore, I have informed the healthcare provider of any information I do not wish to be transmitted through electronic communications.
- \_\_\_\_\_ By signing below, I understand the inherent risks of errors or deficiencies in the electronic transmission of health information and images during a telehealth visit.
- \_\_\_\_\_ I understand that there is never a warranty or guarantee as to a particular result or outcome related to a condition or diagnosis when medical care is provided.
- \_\_\_\_\_ To the extent permitted by law, I agree to waive and release my healthcare provider and his or her institution or practice from any claims I may have about the telehealth visit.
- \_\_\_\_\_ **I understand that electronic communication should never be used for emergency communications or urgent requests. Emergency communications should be made to the provider's office or to the existing emergency 911 services in my community.**

I certify that I have read and understand this agreement and that all blanks were filled in prior to my signature with the opportunity to have questions answered to my satisfaction.

For electronic communication between \_\_\_\_\_ and staff and \_\_\_\_\_.  
*(Healthcare provider's name)* *(Patient's name)*

\_\_\_\_\_  
Patient or Legal Representative Signature/Date/Time

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Print Patient or Legal Representative Name

\_\_\_\_\_  
Witness Signature/Date/Time

I certify that I have explained the nature of this agreement to the patient/patient's legal representative. I have answered all questions fully, and I believe that the patient/legal representative (circle one) fully understands what I have explained.

\_\_\_\_\_  
Healthcare Provider Signature/Date/Time

\_\_\_\_\_ copy given to patient  
initial

\_\_\_\_\_ original placed in chart  
initial

UH Hilo Student Medical Services is a learning facility, and as such, students from multiple disciplines may be actively involved in your care such as Doctorate and Masters Nursing students, Bachelor's Nursing students and Pharmacy students. All students are supervised by licensed professionals, and your care is coordinated and overseen by the Professional Licensed Nurse Practitioner, RN, and Pharmacist.

**You may, at any point, request to be seen by the supervising professional only (except in cases where a chaperone may be appropriate).**

We appreciate your continued support in allowing this facility to be an invaluable learning experience for our students.

- Yes, I am willing to have a student do my evaluation and/or be present
- No, I do not wish to have a student

Signature \_\_\_\_\_ Date \_\_\_\_\_

# PATIENT RIGHTS and RESPONSIBILITIES and NOTICE of PRIVACY PRACTICES

## PATIENT RIGHTS AND RESPONSIBILITIES

### Rights:

- Patients shall be treated with respect, consideration and dignity.
- Patients shall be provided appropriated privacy.
- Patients may request communication of health information in a manner that best ensures confidentiality.
- Patient disclosures and records are treated confidentially, and except when required by law, patients are given the opportunity to approve or refuse release of their record. Patients may request restrictions on the uses of disclosures of their information, and request an accounting of disclosures of their information
- Patients may revoke authorization of disclosures of their information.
- Patients may amend (add to or append information) their health record.
- Patients will be provided, to the degree known, complete information concerning their diagnosis, treatment and prognosis.
- Patients shall be informed of service fees.
- Patients have the right to refuse to participate in experimental research.
- Patients are provided means for expressing concerns and suggestions to the University of Hawaii at Hilo.
- Patients have the right to change primary or specialty physicians.
- Patients have the right to learn the licensing status of the staff.
- Patients shall be informed of any changes in their rights or responsibilities.

### Responsibilities:

- Patients have the obligation to provide the full and accurate information needed by health service professionals in order to assure proper evaluation and care.
- Patients have the obligation to interact effectively with healthcare providers by asking questions concerning the diagnosis and treatment of their condition and by expressing appropriate concerns about recommended treatments.
- Patients must accept responsibility if they refuse medically recommended care.
- Patients must abide by UHH Student Health Service rules, regulations and policies.
- Patients must assume financial obligations for services received.
- Patients must respect the rights of other Patients and UHH Student Health Service staff.

## NOTICE OF PRIVACY PRACTICES

**IMPORTANT: This notice describes how medical information about you can be used and disclosed; and how you can get access to this information. Please review it carefully.**

### Uses of your Protected Health Information (PHI)

Each time you visit the University of Hawaii at Hilo Student Health Service (UHSHS), a record containing your symptoms, examination and test results, diagnoses, treatment, and plan for future care or treatment is made. Your PHI serves as:

- a basis for planning your care and treatment
- a means for processing and administering claims for payment of (a) physicians, hospitals and others, (b) reimbursements, and (c) supplemental plan benefits, for costs of healthcare services to you, and any auditing functions thereof
- a legal document describing the care you received
- a means by which you or a third-party payer can verify that services billed were actually provided
- a tool in educating health professionals
- a source of data for medical research
- a source of information for public health officials charged with safeguarding and improving health for the public
- a source of data for accreditation, licensing and credentialing activities
- a tool with which we can assess and continually work to improve the quality of care we render and the outcomes we achieve

### Understanding what is in your record and how your health information is used will help to:

- ensure its accuracy
- better understand who, when, where, and why others may access your health information; and
- make more informed decisions when authorizing disclosure to others.

### Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

- receive this notice upon enrollment, when confidentiality practices are substantially amended, and upon request.
- request a restriction on certain uses and disclosures of your PHI
- inspect and obtain a copy of your health record
- amend your health record
- obtain an accounting of disclosures of your PHI within 60 days of your request
- request communications of your PHI in a confidential manner by alternative means or at alternative locations
- revoke your authorization to use or disclose PHI except to the extent that action had already been taken.

### Our Responsibilities

This organization is required to:

- maintain the privacy of your individually identifiable health information
- provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- abide by the terms of this notice
- notify you if we are unable to agree to a requested restriction and
- accommodate reasonable requests you may have to communicate PHI by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you have provided to us.

We will not use or disclose your health information without your authorization, except as described in this notice or as required by law. You may authorize disclosure for other purposes by completing a written authorization that meets the requirements of law. You may revoke such authorization in writing at any time.

Effective Date: August 28, 2001

### **Examples of Disclosures for Treatment, Payment and Health Operations**

We will use your PHI for treatment. For example: PHI obtained by a nurse, physician, or other member of UHSHS's healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Members of your healthcare team will then record follow-up actions they took and their observations. In that way, each provider accessing your record will know what treatment you have received and how you are responding.

We will use your PHI for payment. For example: A bill may be sent to you or a third party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your PHI for regular health operations. For example: Members of UHSHS administrative staff may use information in your health record to assess quality of care, track visit counts or improve customer service. We may also contact you to provide appointment reminders.

As required by law: We may disclose your PHI when required to do so by any other law not already referred to in the following categories:

**Business associates:** There are some services provided to our organization through contracts. Examples include referrals, laboratory test, data or record-management services. When these services are contracted, we may disclose your PHI to these entities so they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your PHI, however, we required these providers to establish appropriate safeguards.

**Coroners, Funeral Directors, Organ Donation:** We may release PHI to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose PHI in connection with organ or tissue donation.

**Duty to warn:** We may disclose PHI when necessary to protect you or others from serious threat of harm.

**Federal oversight:** We may disclose PHI when Federal law makes provision for your PHI to be released to an appropriate health oversight agency, public health authority or attorney, provided that a workforce member or business associate believes in good faith what we have not engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers, or the public.

**Food and Drug Administration (FDA):** We may disclose to the FDA your PHI relevant to adverse events with respect to food, supplements, product and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

**Law enforcement:** We may disclose your PHI for law enforcement purposes as required by law or in response to a valid judge-ordered subpoena.

**Notification:** We may use or disclose PHI to notify or assist in notifying a family member, personal representative, or another person responsible for your care of your location, your condition or your death. If you are unable or unavailable to agree or object to our discussing these matters with your family and/or friends, UHSHS professionals will use their best judgment to determine whether communications with your family or others is necessary and/or appropriate. If you are a minor, your parent or legal guardian generally has the right to obtain access to your health information.

**Public Health:** As required by law, we may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

**Research:** We may disclose your PHI to researchers only when the research has been approved by the University of Hawaii's institutional review board. The Board reviews research proposals and establishes protocols to ensure the privacy of your PHI. Without your authorization, your PHI may be disclosed to research only when it has been de-identified (cannot be linked to you as an individual). Otherwise, we will release your PHI for research purposes only if you have provided specific informed consent.

**Workers compensation:** We may disclose your PHI to the extent authorized by and the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

### **For More Information or to Report a Problem**

If you have any questions or would like additional information, you may contact:

#### **UH Hilo Student Health Service**

200 W. Kawili Street  
Campus Center 212  
Hilo, HI 96720  
Telephone: (808) 974-7636

**If you believe your privacy rights have been violated, you can file a complaint with the director of UH Student Health Services-Hilo (at the below address) or with the secretary of Health and Human Services at:**

#### **Office of the Secretary**

The U.S. Department of Health and Human Services  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
Toll Free: 1-877-696-6775

**There will be no retaliation for filing a complaint**

# UNIVERSITY OF HAWAI'I AT HILO STUDENT MEDICAL SERVICES

## PERSONAL DATA SHEET

PLEASE PRINT CLEARLY IN INK. ALL INFORMATION IS CONFIDENTIAL.

DATE \_\_\_\_\_

NAME \_\_\_\_\_  MALE  FEMALE  
LAST FIRST MI MAIDEN

STUDENT ID # \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ AGE \_\_\_\_\_

LOCAL ADDRESS \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_

PERMANENT ADDRESS \_\_\_\_\_

CITY/STATE/ZIP \_\_\_\_\_ COUNTRY \_\_\_\_\_

CELL/HOME PHONE \_\_\_\_\_ EMAIL \_\_\_\_\_

**EMERGENCY CONTACT:**

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ PHONE \_\_\_\_\_

I authorize the University of Hawai'i at Hilo Student Health Service to perform such treatment as reasonable or necessary for the condition for which I have sought medical care. I authorize release of information from my medical record for billing and to all parties liable for payment of charges, including insurance companies and health care plans.

I have received a copy of the Notice of Patient Rights and Responsibilities and Notice of Privacy Practices which tells how the Student Health Service may use and share my health record.

I understand that all services offered are voluntary and confidential.

I understand that the receipt of family planning services is not a prerequisite for other services and is voluntary and confidential.

Signature \_\_\_\_\_

Limited English Proficiency:  YES  NO REQUESTING A TRANSLATOR:  YES  NO LANGUAGE: \_\_\_\_\_

CITIZENSHIP  U.S. CITIZEN  IMMIGRANT  REFUGEE  STUDENT VISA  TOURIST VISA  OTHER \_\_\_\_\_

RACE (SELECT ONE ONLY)  AMERICAN INDIAN /ALASKA NATIVE  BLACK/ AFRICAN AMERICAN  UNKNOWN/ NOT REPORTED  
 NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER  WHITE  ASIAN  MORE THAN ONE RACE

ETHNICITY:  HISPANIC OR LATINO  NOT HISPANIC OR LATINO

**SUB-RACE (CHECK ALL THAT APPLY)**

- |   |   |  |                                       |  |
|---|---|--|---------------------------------------|--|
| <input type="checkbox"/> BLACK / AFRICAN AMERICAN       | <input type="checkbox"/> CHINESE                    | <input type="checkbox"/> HAWAIIAN                | <input type="checkbox"/> MICRONESIAN: | <input type="checkbox"/> MARSHALLESE     |
| <input type="checkbox"/> AMERICAN INDIAN/ ALASKA NATIVE | <input type="checkbox"/> FILIPINO                   | <input type="checkbox"/> SAMOAN                  | <input type="checkbox"/> CHUUKESSE    | <input type="checkbox"/> PALAU           |
| <input type="checkbox"/> CAUCASIAN/WHITE                | <input type="checkbox"/> JAPANESE                   | <input type="checkbox"/> OTHER PACIFIC ISLANDER: | <input type="checkbox"/> KOSRAEAN     |  |
| <input type="checkbox"/> PORTUGUESE                     | <input type="checkbox"/> KOREAN                     | SPECIFY _____                                    | <input type="checkbox"/> POHNPEIAN    | <input type="checkbox"/> UNKNOWN/REFUSED |
| <input type="checkbox"/> PUERTO RICAN/MEXICAN/CUBAN     | <input type="checkbox"/> VIETNAMESE                 |  | <input type="checkbox"/> YAPESE       |  |
|   | <input type="checkbox"/> OTHER ASIAN: SPECIFY _____ |  |                                       |  |

MARITAL STATUS (CHECK ONE ONLY)  SINGLE  MARRIED  SEPARATED  WIDOWED  DIVORCED

CURRENTLY EMPLOYED?  NO  YES If YES, INCOME \$ \_\_\_\_\_ PER MONTH PER YEAR FAMILY SIZE \_\_\_\_\_

**EDUCATION ACHIEVED (CHECK ONE ONLY)**

HIGH SCHOOL  HIGH SCHOOL GRADUATE/GED  SOME COLLEGE, NO DEGREE  ASSOCIATE DEGREE  BACHELOR DEGREE OR HIGHER

STUDENT STATUS:  NON-STUDENT  HIGH SCHOOL  FULL-TIME COLLEGE  PART-TIME COLLEGE

MEDICAL INSURANCE PLAN  HMSA  KAISER  QUEST  ALOHA CARE  MILITARY  
 NONE  OTHER \_\_\_\_\_

INSURANCE CHANGES: DATE /PLAN \_\_\_\_\_ DATE/PLAN \_\_\_\_\_  
 DATE /PLAN \_\_\_\_\_ DATE/PLAN \_\_\_\_\_

NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ DATE \_\_\_\_\_  
 Last, First, M.

**TO ALL STUDENTS:  
 PLEASE ANSWER THE FOLLOWING QUESTIONS PRIOR TO SEEING THE  
 PHYSICIAN**

**1. Are you allergic to any medications?**

- |                                     |  |
|-------------------------------------|--|
| <input type="checkbox"/> None       | <input type="checkbox"/> Aspirin       |
| <input type="checkbox"/> Sulfa      | <input type="checkbox"/> _____ (other) |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> _____ (other) |

**2. List any medications, herbals, and/or supplements you are now taking:**

\_\_\_\_\_  
 \_\_\_\_\_

**3. List any surgeries, hospitalization, or major illnesses you have had.**

Year - _____	Year - _____
Year - _____	Year - _____

**4. Check off and enter the year of any of the following conditions you have experienced:**

- |                                       |                                     |
|---------------------------------------|-------------------------------------|
| _____ anemia                          | _____ high blood pressure           |
| _____ sickle cell disease             | _____ chest pain                    |
| _____ skin problems                   | _____ shortness of breath           |
| _____ migraine headaches              | _____ heart murmur                  |
| _____ stroke                          | _____ heart disease/problem         |
| _____ seizures                        | _____ asthma                        |
| _____ severe depression               | _____ lung disease                  |
| _____ other mental/emotional problems | _____ blood clots                   |
| _____ sugar diabetes                  | _____ stomach/bowel problem         |
| _____ gall bladder/liver disease      | _____ cancer                        |
| _____ thyroid problem                 | _____ hepatitis                     |
| _____ kidney problems                 | _____ breast lump/discharge/surgery |
| _____ urinary tract infection         | _____ eye/vision problems           |
| _____ other _____                     |                                     |

**5. List any medical problems (cancer, diabetes, heart attacks, etc.) your family member(s) have experienced:**

Condition:	Relationship: