Patient Registration Form

WINDWARD
vein | heart | medispa

Patient Name

Date of Birth Gender

Address City/Zipcode

Email Emergency Contact Name

Home Phone Cell Phone Emergency Contact #

Pictures will be obtained for medical records. In the event that any pictures are used for educational or marketing purposes, all identifying features will be cropped or removed. Please initial to acknowledge this notice: _____

☐ Check to receive our specials and event invitations.

☐ Check to receive email reminders for appointments.

How did you hear about Dr.Wong and his staff?

___ Friend or Family ___ Yelp ___ Midweek ___ Ref. Dr. _____

___ Google Search ___ Flyer ___ Facebook ___ Other _____

FACE: What are your skin concerns? (check all that apply)

___ Sun Damage ___ Rosacea ___ Enlarged Pores ___ Sensitivity

___ Loss of Elasticity ___ Dehydration ___ Acne/ Problematic ___ Scars

___ White/ Blackheads ___ Uneven Texture ___ Hyperpigmentation ___ Dilated Capilaries

BODY: What are your concerns? (check all that apply)

___ Muscle Tension ___ Stress ___ Discomfort ___ Loss of Firmness

___ Dry Skin ___ Oily Skin ___ Cellulite ___ Circulation

___ Dark Spots ___ Arthritis ___ Loss of Elasticity ___ Dehydration

COSMETIC INTERESTS (check all that apply)

___ Dysport / Botox Injectable ___ CoolSculpting Fat Reduction ___ PicoSure Acne Scar Removal

___ Dermal Fillers ___ LiLa Strawberry Laser Lipo ___ Laser Hair Removal

___ Medical Grade Facials ___ Ultherapy Ultrasound Skin Tightening ___ Eyelash Growth

___ Brow Shaping ___ PicoSure Laser Skin Revitalization ___ Therapeutic Massage

___ Environ Skincare Products ___ PicoSure Laser Pigmentation Removal ___ Bowen Therapy

___ Oncology Esthetics ___ PicoSure Laser Tattoo Removal ___ Spider/ Varicose Vein Removal

Signature

Date

Sonny J.H. Wong, MD, FACC
25 Maluniu Ave, Suite 202
Kailua, HI 96734
ph 808.261.VEIN
windwardmedispa.com

Patient Partnership Agreement

Thank you for choosing Windward Medispa & Vein Center for your health care and aesthetic needs. This document details what we ask of you as we enter into a partnership to provide your medical care. If you have any questions, please don't hesitate to ask.

Please pay charges at time of service

All aesthetic treatment charges are due at time of service.

Charges such as co-pays, co-insurance payments and deductibles are also due at time of service.

For those patients having procedures covered by insurance plans, we will file a claim to your primary insurance carrier to receive payment for your visit. Please note, if your health insurance plan does not provide reimbursement of the claim within 60 days after your appointment the unpaid balance will become your responsibility.

Appointments

As a courtesy, Windward Medispa & Vein Center staff will strive to contact and remind you 2 days before your scheduled appointment.

Please arrive 15 minutes before your appointment time is scheduled to allow for the check-in process. We strive to ensure that your appointment begins at the time that it is scheduled, and the check-in process occurs prior to your appointment.

Cancellations

If you are unable to make your appointment, please let us know as soon as possible so we can allow another patient to receive care during that time. Please call us at least 48 hrs before any appointment if you need to cancel or reschedule. If you miss your appointment, and do not call to cancel or reschedule within the requested time, a missed appointment fee will be charged to your credit card on file.

Missed Appointment/ Late Cancelation Fees

- $50 for Vein Consultations
- $75 for Spider Vein Sclerotherapy or Laser
- $200 for Endovascular Ablation
- $50 per half hour for any cosmetic appointment, apart from CoolSculpting, Ultherapy, LiLa Laser and PicoSure Laser.
- CoolSculpting, Ultherapy, LiLa Laser, & PicoSure Laser: The required scheduling deposit will be forfeited.
- Groupon users will lose one treatment.

I have read and understand this document and agree to abide by its terms. All of my questions regarding this document have been explained to me.

I understand that charges not covered by my health insurance plan, or not paid to Windward Heart Center LLC doing business as Windward Medispa and Vein Center, Sonny J.H. Wong, M.D., F.A.C.C. within 60 days of the service rendered, as well as any applicable fees, co-payments, and deductibles, are my responsibility.

I authorize my insurance benefits to be paid directly to Windward Heart Center LLC doing business as Windward Medispa and Vein Center, Sonny J.H. Wong, M.D., F.A.C.C. I authorize Windward Medispa and Vein Center to release pertinent medical information to my insurance company when requested to facilitate payment of a claim.

Patient Name (please print) _____

Primary Insurance Company Name: _____

Subscriber Name _____ Subscriber Date of Birth _____

Subscriber ID# _____ Group # _____ Relationsip to Patient _____

Secondary Insurance Company Name: _____

Subscriber Name _____ Subscriber Date of Birth _____

Subscriber ID# _____ Group # _____ Relationsip to Patient _____

Signature _____

Date _____

Sonny J.H. Wong, MD, FACC
25 Maluniu Ave, Suite 202
Kailua, HI 96734
ph 808.261.VEIN
windwardmedispa.com

HIPAA Notice of Privacy Practices

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.

This Notice of Privacy Practice describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It
also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosure of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of
the office that are involved in your care, for the purpose of providing healthcare services to you, to pay
your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment
We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of you healthcare with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you; or your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment
Your protected health information will be used, as needed, to obtain payment for you health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the
health plan to obtain approval for the hospital admission.

Healthcare Operations
We may use or disclose, as-needed, your protected health information in order to support our practice's activities, training of medical students, and licensing. For example, we may disclose your protected health information to medical school students that see patients at our office. In our day to day practice activities, we may use a sign-in sheet at the registration desk , we may also call you by name in the waiting room when your physician is ready to see you. Your protected health information may also be used to contact you to remind you of an appointment.

Disclosures Not Requiring Your Permission
Windward Heart Center may make disclosures of your protected health information to or regarding the following when
required by law.

Your Rights to Privacy
Your medical information will not be shared and/or disclosed to anyone without your permission except as described in this notice or required by law. You may, in writing, revoke this authorization at any time. You have the right to request to receive confidential communications from us by alternative means or at an alternative location.

WINDWARD
vein | heart | medispa

You have the right to inspect and copy your protected health information. If you request a copy of the information we may charge a reasonable fee for the cost of copying, mailing or other supplies associated with your request. Under federal law, however, you may not inspect or copy psychothearapy notes; information completed in reasonable anticipation of, or use in a civil criminal, or administrated action or proceeding, and protected health information that is subject to law that prohibits health information. You also have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information, as well as extra copies of this notice.

You have the right to request a restriction or an amendment of your protected health information. This means that you ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care. Your request must state the specific restrictions requested and to whom you want the restriction to apply. Please note, your physician is not required to agree to a restriction or amendment that you may request if they believe it is in your best interest. You then have the right to use another healthcare professional or file statement of disagreement with us.

Complaints
You may complain to us or to the Secretary of Health and Human Services if you have concerns about your privacy.
We will not retaliate against you for filing a complaint.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. This notice became effective April 14, 2003.

Print Name_____

Signature _____

Date _____

Signature is only acknowledgement that you have received this notice of our Privacy Practices.

Sonny J.H. Wong, MD, FACC
25 Maluniu Ave, Suite 202
Kailua, HI 96734
ph 808.261.VEIN
windwardmedispa.com