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STATE OF HAWAI'I

**Electronically Filed**  
**FIRST CIRCUIT**  
**1CC191001419**  
**19-DEC-2025**  
**10:27 PM**  
**Dkt. 574 EXH**

IN THE CIRCUIT COURT OF THE FIRST CIRCUIT  
STATE OF HAWAI'I

JOHN ROE NO. 121,

Plaintiff,

vs.

STATE OF HAWAI'I; JOHN A. TEIXEIRA;  
JOHN DOES 1-10; DOE CORPORATIONS  
1-10; DOE PARTNERSHIPS 1-10; DOE  
NON-PROFIT ENTITIES 1-10; and DOE  
GOVERNMENTAL ENTITIES 1-10,

Defendants.

CIVIL NO.: 1CC191001419  
(Other Non-Motor Vehicle Tort)

JOINT TRIAL EXHIBIT 36

Judge: Honorable Kevin T. Morikone  
Trial: April 22, 2024



# Kāhi Mōhala

Outpatient Services

**Ewa Office**  
91-2301 Fann Weaver Road  
Ewa Beach, Hawaii 96706  
(808) 677-2517

**Honolulu Office**  
1314 S. King St., Suite 1101  
Honolulu, HI 96814  
(808) 596-0900

**Windward Office**  
970 N. Kalia Ave., Suite 1202  
Kalihi, HI 96714  
(808) 254-1133

## PATIENT INFORMATION

PATIENT NAME: M. [REDACTED] Jr.  
(LAST) (FIRST) (MI)

Address: DH2/AU 420 Waiakeamilo Rd #300B City: Honolulu State: HI Zip Code: 96817-4941

Home #: [REDACTED] Birthdate: [REDACTED] SS#: [REDACTED] Marital Status: N/A

IF STUDENT: SCHOOL: Mali Elementary Grade Level: 2

NAME OF EMPLOYER: N/A Business Phone: \_\_\_\_\_

DO YOU HAVE MEDICARE? YES X NO \_\_\_\_\_

PRIMARY INSURANCE: AlohaCare Quest 0000176351. (Also 06/01/98 will be HMOA)

Subscriber name: Quest Policy #: 176351

Group #: Aloha99 Coverage Code: \_\_\_\_\_ Effective Date: \_\_\_\_\_

SECONDARY INSURANCE (if applicable): \_\_\_\_\_

Subscriber name: \_\_\_\_\_ Policy #: \_\_\_\_\_

Group #: \_\_\_\_\_ Coverage Code: \_\_\_\_\_ Effective Date: \_\_\_\_\_

RESPONSIBLE FOR PAYMENT: DH2-Adoptions Unit (AU) (if HMOA will not cover) SS#: \_\_\_\_\_

Address: 420 Waiakeamilo Rd #300B City: Honolulu State: HI Zip: 96817-4941

Relationship: Legal Custodian Hm Phone #: \_\_\_\_\_

Employer: \_\_\_\_\_ Wk Phone #: 832-5445

PERSON TO CONTACT IN CASE OF EMERGENCY: Julie Teuteau, DH2 AU Social Worker

Address: 420 Waiakeamilo Rd #300B City: Honolulu State: HI Zip: 96817-4941

Relationship: Social Worker Home Phone: [REDACTED] Work Phone: 832-5474

WHO REFERRED YOU?: \*24 hour hotline 832-5300 Phone #: \_\_\_\_\_

SIGNED: Julie Teuteau, DH2 SW DATE: 05/27/98

WITNESSED: Mary Zetter, DH2 SW DATE: 5/27/98

OFFICE USE ONLY: Intake #: \_\_\_\_\_ Patient #: \_\_\_\_\_ Patient History #: \_\_\_\_\_

INSURANCE VERIFIED BY: \_\_\_\_\_ DATE: \_\_\_\_\_ PHONE #: \_\_\_\_\_

SPOKE WITH: \_\_\_\_\_ COVERAGE: \_\_\_\_\_

9/2/2008 2:00 PM

MAY 22 1998 1:11 PM KAHIMOHALA-ADM

CONFIDENTIAL-SUBJECT TO PROTECTIVE ORDER

SOH 002508



**Kāhi Mōhala**

Outpatient Services

**OUTPATIENT MULTIPLE CONSENT**

**Ewa Office**  
91-2301 Fort Weaver Road  
Ewa Beach, Hawaii 96706  
(808) 935-2517

**Honolulu Office**  
1314 S. King St., Suite 1100  
Honolulu, HI 96814  
(808) 596-0990

**Windward Office**  
970 N. Kalanianaʻone Ave., Suite A202  
Kalihi, HI 96734  
(808) 254-1133

**CONSENT TO TREATMENT**

I hereby request outpatient services for myself, \_\_\_\_\_  
or my child 1. [REDACTED] M. [REDACTED] Jr.

I agree to accept treatment(s) recommended by the clinical staff and medication(s) recommended by the treating psychiatrist, after having the opportunity to participate in the development of an individualized treatment plan. I understand that I may refuse treatment recommendations, unless the treating psychiatrist believes a psychiatric emergency exists.

[Signature]  
Please Initial

**RELEASE OF CONFIDENTIAL INFORMATION TO INSURANCE CARRIERS**

I authorize Kahi Mōhala to disclose to my insurance carrier(s) information necessary for the processing of my insurance claims. This information may contain alcohol and/or substance abuse information. I understand that Federal Law prohibits redisclosure of this information by the insurance carrier. I authorize Kahi Mōhala to contact the member/sponsor, if necessary, in order to obtain additional information concerning insurance coverage, certification, and/or verification. This consent expires 12 months from date of discharge, or upon my revocation of this consent, whichever comes first.

[Signature]  
Please Initial

**ACKNOWLEDGMENT OF ACCOUNT**

For and in consideration of the provision of services to me at my request, I accept and acknowledge the responsibility for the payment of this account. The decisions of other persons, parties or insurance companies regarding the payment of this account in its entirety.

\*I understand that my account may be billed for missed appointments and appointments that are not cancelled within 24 hours.

\_\_\_\_\_  
Patient Signature (15 Years or older)

\_\_\_\_\_  
Date

[Signature]  
Parent/Guardian's Signature

05/27/98  
Date

[Signature]  
Witness

5/27/98  
Date

Mult Consent  
Rev 5/98

A Sutter Health Affiliate

9/3/98 280,082

KAH I MOHALA-ADM.

1:11PM

MAY.22.1998

**CONFIDENTIAL-SUBJECT TO PROTECTIVE ORDER**

**SOH 002509**

*John Roe 121 v. State of Hawai'i, et al.*

Civil No.: **1CC191001419**

Defendant's Exhibit: **JT36**

Marked for Identification: \_\_\_\_\_

Received into Evidence: \_\_\_\_\_

\_\_\_\_\_  
Clerk, First Circuit Court