Kapolei Family Medical Center, INC

TERMS AND CONDITIONS OF TREATMENT

Consent for Treatment

I wish to receive medical care and treatment at Kapolei Family Medical Center, Inc.; accordingly, I consent to the procedures, which may be performed during this clinic visit, including emergency treatment. I authorize and consent to any of the following: Laboratory procedure, other diagnostic procedures, medical or surgical treatment, or other clinical services as directed by my physician(s), which my physician(s) believes are advisable to evaluate or treat me, and to other services rendered under general and special instructions of my physician(s). I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that this facility has not made any guarantees to me as to the results of treatments or examinations. I am also aware that I should ask my physician any questions that I may have about the diagnosis, treatment, risks of complications, alternative of treatment, and/or anticipated results of treatment.

Disclosure of Information for Payment Process

I understand my medical information will be sent to my insurance carrier for billing purposes for any treatment I may receive at this medical facility including treatment Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS), mental health diagnosis and/or drug, alcohol or other substance abuse. I understand that according to Hawaii law, I may choose to pay for services pertaining to HIV or AIDS treatment if I do not want my health information provided to my insurance company. I agree to notify this medical facility of my wishes regarding payment before these services are provided. I also understand that if I fail to pay for the service the information will be sent to my insurance company.

Information to other Providers

I understand the during my treatment and/or planning for my care, my information may be shared electronically or on paper with other providers. If I prefer that this medical facility not use or share my information, I may submit a written request for consideration per this facility's Notice of Privacy Practice.

Non-Discrimination Policy

This medical facility will admit and treat patients within its capabilities regardless of race, color, national origin, religious beliefs, sex, sexual orientation, martial status, veteran's status, age, political beliefs, or disability.

Financial Agreement

I understand and agree to pay all charges for services rendered and that I am obliged to pay for services in accordance with the regular rates and terms of this medical facility at the time of my visit. The physician(s) may also bill me separately for their services provided to me while at this facility. This medical facility reserves the right to charge a Late Payment Fee and/or a Returned Check Fee. Should my account be referred to an attorney or collection agency for collections, I agree to pay any reasonable attorney's fee, collection expenses and interest at the statutory rate on all delinquent accounts, whether the account is referred to by a collection agency. I further understand that not all physician(s) are not employees of this facility.

Medicare Coverage (if applicable)

I certify that the information I have been given in applying for payment under Medicare is correct. I authorize the Social Security Administration to release information about my Medicare effective dates and Medicare claim number to this medical facility. I authorize any holder of medical or related information about me to release any information needed to process this or a related Medicare claim to the Social Security Administration or its intermediaries. I request that payment of benefits be made on my behalf to this medical facility for any services provided to me by this medical facility.

Assignment of Benefits

I hereby authorize the assignment of my medical insurance benefits I am due to this medical facility for application to the bill for medical services and supplies I received. I further authorize this medical facility to receive direct payment from all such benefits payments. I agree to remain responsible and liable for payments of all accounts due to this medical facility and not receive from my insurance carrier(s). I understand this medical facility is submitting claims on my behalf as a curtesy. I SHALL REVOKE THIS ASSIGNMENT FOR ANY REASON.

Patients' Rights and Responsibilities

My signature below confirms that I have received the information on my Rights and Responsibilities as a patient.

I have read this consent, and I am the patient, of the patient's daily authorized representative. On my behalf (or on behalf of the patient), I accept and agree to be bound by all these TERMS AND CONDITION'S OF SERVICE.

_____ or _____ _____

Patient Signature Representative signature date

_____ _____ _____

Print Name Relationship to patient contact number

Address

Emergency Contacts Name and Phone number