THE QUEEN'S HEALTH CARE CENTERS

HONOLULU, HAWAII

CONSENT FOR TREATMENT

☐ **HAWAII KAI**
377 KEAHOLE STREET
HONOLULU, HI 96825
PHONE (808) 396-6675

☐ **DOWNTOWN**
550 S. BERETANIA STREET
SUITE #401
HONOLULU, HI 96813
PHONE (808) 691-7744

☐ **KAPOLEI**
599 FARRINGTON HWY.
SUITE #201
KAPOLEI, HI 96707
PHONE (808) 674-9500

CONSENT TO TREATMENT

I authorize and consent to medical care and treatment at QHCC (including diagnostic tests and procedures) which my treating physicians and medical providers find to be necessary and which is given or performed at their direction. I understand that any requests or restrictions related to my treatment must be discussed with my physician.

NOTICE OF PRIVACY PRACTICE

My signature below will confirm that I have been given a copy of the QHCC - Notice of Privacy Practice.

FINANCIAL AGREEMENT

Assignment of Insurance Benefits and Payment

I understand that I am responsible for paying my bill in full. If I am entitled to any insurance benefits, I assign all of these benefits to QHCC toward payment of my bill and direct my insurance carrier to pay these benefits to QHCC. QHCC will bill my insurance carrier if I provide the appropriate information in a timely fashion.

Late Payment Charge: A late payment charge of 1% per month, calculated at simple interest, will be assessed on all accounts not paid in full within 90 days (or longer if required by law).

Collection: If the bill is not paid in full within 90 days (or longer if required by law) I understand that QHCC may refer the matter to an attorney and/or collection agency and that I will be responsible for paying all legal fees and other costs incurred to collect my bill.

No Show Policy: We kindly request that you notify us 24 hours in advance of a cancelled and/or rescheduled appointment. Failure to do will result in a No Show fee. This fee will not be covered by your insurer.

Appointments are in high demand and your early cancellation will give another person the possibility to have access to timely medical care.

If I have CHAMPUS Coverage:

I request payment to QHCC of authorized benefits for all services furnished me by QHCC.

If I have Medicare Coverage:

I certify that the information given to me in applying for payment under Medicare is correct. I authorize the Social Security administration to release information on my Medicare effective dates and Medicare Claim number to QHCC. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries any information needed for this or any related Medicare claim. I request that payment of benefits be made to QHCC on my behalf.

RELEASE OF INFORMATION

I understand that my health information for this course of treatment may be disclosed for the purpose of treatment, for obtaining payment from my insurers and other payors and for other qualified health care operations, within the limits of the law. I further understand that certain specific categories of my health information require my consent before release. If my medical records for this course of treatment contain any information related to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), mental health diagnosis and treatment, and/or my treatment in a federally funded substance abuse treatment program, I consent to release such health information for the purpose of treatment, for obtaining payment from my insurers and other payors and for other specific insurer/payor requirements, within the limits of the law.

I certify that I have read this Consent and that I am the patient, or the patient's authorized representative, and I accept and agree to be bound by the Consent, a copy of which will be made available upon request.

X _____
PRINT NAME OF PATIENT

X _____ Date: _____ Time: _____ : _____ a.m. p.m.
SIGNATURE OF PATIENT

X _____ Date: _____ Time: _____ : _____ a.m. p.m.
SIGNATURE OF PATIENT'S REPRESENTATIVE

_____
RELATIONSHIP TO PATIENT