NOTICE OF PRIVACY PRACTICES, FINANCIAL RESPONSIBILITY & AUTHORIZATION TO LEAVE PERSONAL HEALTH INFO (PHI)

Office Use Only:*__________ *(CSR initial)
**My initial signifies that all portions of the form has been completed.*

PATIENT NAME:______________________________ **DATE OF BIRTH:**______________

NOTICE OF PRIVACY PRACTICES AND FINANCIAL RESPONSIBILITY

1. CONSENT FOR TREATMENT: Urgent Care Hawaii, LLC and their employees evaluate and treat the above patient for medical complaint and illnesses. This includes taking of medical information, evaluation by physical examination, obtaining of bodily fluids for laboratory testing, obtaining of X-rays for diagnosis, the administration of medications for treatment, and any other treatment or evaluation that may be necessary. If, at any time, I do not wish to have these services rendered, I may state so and they will not be provided, but an AMA form may need to be signed by the patient. All my information will remain confidential. I also understand Urgent Care Hawaii, LLC, may use or disclose any Protected Health Information (PHI) necessary to carry out treatment, payment or healthcare operations. I acknowledge that I have the authority to request for a copy of Urgent Care Hawaii, LLC Notice of Privacy Practices. **ASSIGNMENT OF BENEFITS:** I authorize the release of any medical information and payment of medical benefits to Urgent Care Hawaii, LLC for services necessary to process this claim and any future claims. I agree to be responsible for any deductible, co-insurance, co-pay, or any other balance not paid by my insurance.

2. FINANCIAL POLICY: We are committed to providing you with the best possible medical care; if you have special needs, we are here to work with you. The following information is provided to avoid any misunderstanding or disagreement concerning payment of professional services. **PAYMENT IS DUE IN FULL AT THE TIME OF SERVICE**: Co-payments and any balances on your account will be collected before you are seen. Payment can be made by cash or credit card; you will also have the option to pay online or submit a check to our billing department upon receiving your statement from us. **NON-PARTICIPATING INSURANCE PLANS:** If you have insurance that we do not participate with, our office will be happy to file the claim upon request; however, payment in full is expected at the time of service. If you have questions about your insurance coverage, we will be happy to assist you. Specific coverage issues should be directed to your insurance company. It is however, understood and agreed that the Responsible Party is responsible for all monies due for services rendered in the event insurance does not pay for these services rendered in the event insurance does not pay for these services. *ALL CHARGES ARE AN ESTIMATE AND FINALIZED WHEN YOUR INSURANCE COMPANY PROCESSES YOUR CLAIMS.* **SELF-PAY:** If I am paying for my visit out-of-pocket, a 20% DISCOUNT is already applied to the total bill at the time of service. This discount does not apply to patients with insurance. If laboratory tests must be sent to an outside source for further evaluation, the responsible party understands they will be responsible for charges from that facility. **NOTE:** It is company policy to run your check by EFT or your credit card. Upon departure, the aging of your statement will begin until your balance has been paid in full by your insurance or by yourself and/or guardian.

3. CREDIT/DEBIT CARD ON FILE: a Pre-Authorization up to the amount of no more than $300 can be held for those charges not paid by your insurance for ALL visits from your consent today. The amount is not charged against the current credit/debit card transaction being processed, unless you have chosen to continue to use this card. The amount is saved for later reference and will be released within 90 days. By providing your email address, you will be notified 3-5 days prior to any charge to the email address provided. If you DO NOT provide an email address, you will NOT be notified of this charge. If at anytime you choose to remove your consent, please notify our FD team and you will need to complete a new form.

× **DECLINE OF PRE-AUTHORIZATION**, please initial here:________. ****By declining the pre-authorization amount you understand that I will need to pay for my deductible/allowable charges for the office visit that can be up to $200 plus tax today before you leave*.***

4. UNDISCLOSED RELATED INJURIES: If you are being treated for a Work-Related Injury or Motor Vehicle Injury but do not disclose it to our staff, any denial or unpaid portion of the bill will be processed first through my private insurance. If your private insurance does not pay, then you understand that you are responsible for the balance.

5. COMMUNICATION CONSENT: You expressly consent and agree that, in order to discuss or service your accounts(s) (the "Accounts ") or to collect amounts you may owe, URGENT CARE HAWAII, LLC, and its officers, agents, affiliates, employees, and any affiliated or associated service providers and any third-party debt collection agency associated therewith (collectively, "We") may contact you by telephone at any telephone number associated with the Accounts, including wireless telephone numbers, which could result in charges to you. You expressly consent and agree that We may also contact you by sending text messages, emails, using any e-mail address you provide to us, or by pre-recorded or artificial voice or voice messages, automatic dialing methods, systems, or devices, and pre-recorded or artificial voice prompts at any telephone number associated with the Accounts, including wireless or mobile telephone numbers, regardless of whether you incur charges as a result.

SIGNATURE:______________________________ **DATE SIGNED:**______________

CONSENT TO LEAVE PERSONAL HEALTH INFO (PHI)

I understand that URGENT CARE HAWAII, LLC may need to contact me using all contact information provided on my registration form, this includes my emergency contact and/or guardian (if I am under 18 years old) listed. I understand that URGENT CARE HAWAII, LLC may leave a detailed message to any form of communication I indicate on my registration form. If for any reason I cannot be reached and need to be contacted immediately I understand that URGENT CARE HAWAII, LLC will attempt to send a certified letter to the address on file and/or contact may guarantor (if I am under 18 years old) and/or emergency contact. I understand that that only myself, my guarantor and/or emergency contact can obtain medical information and personal information regarding my visit(s) with URGENT CARE HAWAII, LLC. I may revoke this authorization at any time by giving written notice. I understand that my revocation will not affect any use or disclosure of my PHI that was made in reliance on the authorization before I revoked it. My health provider cannot require me to sign this authorization in order to be eligible for services or treatment. It is possible that the persons who receive information based on this authorization may disclose it to others and as a result the information may no longer be protected by federal privacy rules. This Authorization for my personal health information does not apply to the release of the same information for any spouse or child that I may cover on my medical benefits or account at URGENT CARE HAWAII, LLC. I understand that my spouse or child over 18 must provide independent Authorization for release of their personal PHI. **I acknowledge that I have the opportunity receive a signed a copy of this authorization if I request for a copy..** With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify URGENT CARE HAWAII, LLC should I change one or more of the telephone numbers OR any one of the contact names.

SIGNATURE:______________________________ **DATE SIGNED:**______________