KAPI'OLANI MEDICAL CENTER FOR WOMEN & CHILDREN

An affiliate of Hawaii Pacific Health

KAPI'OLANI BEHAVIORAL HEALTH SERVICE TERMS AND CONDITIONS OF SERVICE

PATIENT NAME / Information

1. ***Consent for Treatment***

   I or my minor child/ward wish to receive mental health/psychiatric/ psychology and treatment at Kapi'olani Behavioral Health Service (KHBS). Accordingly, I give consent for any and all mental health services rendered to me or my minor child/ward under the general and specific instructions of the attending psychiatrist/psychologist as may be determined to be appropriate by their professional judgment.

   I am aware that the practice of medicine/psychiatry, psychology is not an exact science. I acknowledge that this facility has not made any guarantees to me or my minor child/ward as to the results of treatments or examinations. I am also aware that I should ask the therapist/nutritionist any questions that I may have about my or my minor child's/ward's diagnosis, treatment, risks or complications, alternative forms of treatment, and/or anticipated results of treatment.

2. ***Disclosure of Information for Payment Purposes***

   I understand my or my minor child's/ward's health medical information will be sent to my insurance carrier for billing purposes for any treatment or counseling I may or my minor child/ward may receive at this medical facility. As such, I understand that this health information may contain entries or information relating to sexually transmitted diseases, including Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS), mental health diagnoses, psychiatric impairment and/or drug, alcohol or other substance abuse and other personal information.

   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 or my child's/ward's health information to be provided to my insurance company. I agree to notify KHBS of my wishes regarding payment before these services are provided. I also understand that if I fail to pay for the services, the information will be sent to my insurance company.

3. ***Information to other providers***

   I understand that in the course of my treatment and/or making arrangements for my care, my information may be shared with other providers. If I prefer that KHBS not use or share my information for this purpose, I may submit a written request for consideration per this facility's Notice of Privacy Practices.

4. ***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, marital status, veteran's status, age, political beliefs, or disability.

5. ***Financial Agreement***

   I understand that I will receive a bill from this medical facility for these services. I understand and agree to pay all charges for services rendered and that I am obligated to pay for services in accordance with the regular rates and terms of this medical facility. This medical facility reserves the right to charge a Late Payment Fee and/or a Returned Check fee.

   If I choose to pay all charges myself, I will notify this medical facility prior to receiving service.

   Should the account be referred to an attorney or collection agency for collections, I agree to pay any reasonable attorney's fees, collection expenses and interest at the statutory rate on all delinquent accounts, whether or not the account is referred to a collection agency.

   Missed Appointments: I also agree to pay for all visits missed or canceled late unless I notify KHBS of the cancellation at least 24 hours in advance of the scheduled appointment. I recognize that missed appointments and late cancellations will be charged directly to me unless prohibited by my insurance plan. These fees will not be billed to my insurance.

   Prescription Refills: I understand that controlled substance prescriptions expire 72 hours after being written by the doctor. If I fail to get the prescription filled with in the 72 hours I will be charged fee for my doctor to rewrite the prescription. This fee will not be billed to my insurance.

6. ***Medicare Coverage (if applicable)***

   I certify that the information I have given in applying for payment under Medicare is correct. 1 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.

7. ***Assignment of Benefits***

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

8. ***Patient's Rights and Responsibilities***

   My signature below confirms that I agree to these terms and conditions and that I have received the information on my Rights and Responsibilities as a patient.

ACKNOWLEDGEMENT OF RECEIPT OF THIS MEDICAL FACILITY'S NOTICE OF PRIVACY PRACTICES

________ I HAVE RECEIVED A COPY OF THIS FACILITY'S NOTICE OF PRIVACY PRACTICES

________ THE PATIENT OR THEIR DULY AUTHORIZED REPRESENTATIVE IS UNABLE TO MAKE THIS ACKNOWLEDGEMENT.

MINORS OR INCAPACITATED PERSONS - THE PATIENT IS:

☐ A MINOR _______ YEARS OF AGE

☐ INCAPACITATED AND UNABLE TO SIGN FOR THE FOLLOWING REASON(S): ____________________

I HAVE READ THIS CONSENT AND I AM THE PATIENT, OR THE PATIENT'S DULY AUTHORIZED REPRESENTATIVE. ON MY OWN BEHALF (OR ON BEHALF OF THE PATIENT), I ACCEPT AND AGREE TO BE BOUND BY ALL OF THESE TERMS AND CONDITIONS OF SERVICE.

X ______________________________ ____________ ____________

PATIENT OR REPRESENTATIVE'S SIGNATURE DATE TIME

______________________________ ______________________________

PRINT NAME REPRESENTATIVE'S RELATIONSHIP TO PATIENT

REPRESENTATIVE: PLEASE DESCRIBE YOUR AUTHORITY TO ACT ON BEHALF OF THE PATIENT: ____________________

WITNESS SIGNATURE ______________________________ ____________ ____________ ____________

DATE TIME PLACE