1. ***Consent for Treatment***
I wish to receive medical care and treatment at Kapiʻolani Medical Center for Women and Children. Accordingly, I consent to the procedures, which may be performed during this hospitalization or clinic visit, including emergency treatment. I authorize and consent to any of the following: X-ray examination, laboratory procedure, other diagnostic procedures, medical or surgical treatment, or other clinical and hospital services as directed by my physician(s) or my physician's(s) assistants, which my physician(s) believes are advisable to evaluate or treat me, and to other services rendered under the 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 my diagnosis, treatment, risks or complications, alternative forms of treatment, and/or anticipated results of treatment.

2. ***General Duty Nurse***
I understand that it is the standard practice of this medical facility to provide general duty nursing care. This medical facility shall not be responsible to provide additional nursing care. If I need or desire additional nursing services, I will be responsible for obtaining and paying for such services.

3. ***Disclosure of Information for Payment Purposes***
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 for Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS), mental health diagnoses, 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 to be 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 services, the information will be sent to my insurance company.

4. ***Information to Other Providers***
I understand that this facility may share my information electronically or on paper with other providers in the course of my treatment, and/or making arrangements for my continuing care, or upon request when seeking care from other providers. Examples of shared information may include, but are not limited to, mental health, cosmetic procedures, medications, and other past medical history. 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 Practices.

5. ***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.

6. ***FINANCIAL AGREEMENT***
I understand that I will receive a bill from this medical facility. The physician(s) may also bill me separately for their services provided to me while at this facility. I further understand not all physicians are employees of this medical facility. 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.

7. ***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.

8. ***Assignment of Benefits***
I hereby authorize 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 authorized 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 SHALL NOT REVOKE THIS ASSIGNMENT FOR ANY REASON.

9. ***Personal Valuables (in-patient only)***
To the extent that I am able to function without prosthetic devices (e.g., dentures, eyeglasses, hearing aides, etc.), I am encouraged to send them and other valuables or personal property home while I am hospitalized. I will not hold this medical facility liable for loss of, or damage to, my personal property regardless of its nature or value.

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

11. ***In-Patient Directory Information Preference (Initial)***
_____ FULL INFO _____ NO INFO

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 the 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**

HAWAIʻI PACIFIC HEALTH | KAPIʻOLANI MEDICAL CENTER FOR WOMEN & CHILDREN

TERMS AND CONDITIONS OF SERVICE

☐ Inpatient ☐ Outpatient ☐ Emergency Room

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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**

HAWAIʻI PACIFIC HEALTH | KAPIʻOLANI MEDICAL CENTER FOR WOMEN & CHILDREN

TERMS AND CONDITIONS OF SERVICE

☐ Inpatient ☐ Outpatient ☐ Emergency Room