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

Office Use Only:__________ (CSR initial)
**My initial signifies that the information has been reviewed and true*

Patient Name:____ Date of Birth:______________________

NOTICE OF PRIVACY PRACTICES

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.

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. 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. I understand that if I am being treated for a Work Related Injury or Motor Vehicle Injury, that any denial or unpaid portion of the bill will be processed first through my private insurance. If my private insurance does not pay then I understand that I am responsible for the bill.

In addition, **a Pre-Authorization up to the amount of no more than $300 can be held for those charges not paid by your insurance.** The Pre-Authorization 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. I understand that I will be notified 3 days prior to any charge to the email address provided. If I do not provide an email address, I understand I may not be notified of the charge.

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, please note that the aging of your statement will begin until your balance has been paid in full by your insurance or by yourself and/or guardian.
With my signature below, I understand the terms listed above.

SIGNATURE:____ DATE SIGNED:__________________

AUTHORIZATION 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 the provided phone number listed on my registration form and/or may send me a detailed message by email. 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 to URGENT CARE HAWAII, LLC. 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. I understand that if it has been more than a year from my last visit I will be required to complete a new form to update the information above.
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:__________________