Access Medical CLINICS

# *TERMS AND CONDITIONS OF SERVICE*

***Consent for Treatment***
***I wish to receive medical care and treatment at Access Medical Clinics. I consent to the procedures which may be performed during this clinic visit. I authorize and consent to any of the following: laboratory procedure, other diagnostic procedures, medical or surgical treatment, or other clinical services as directed by my physician or physician's assistant, which my physician believes are advisable to evaluate or treat me, and to other services rendered under the general and special instructions of my physician.***

***I acknowledge that this clinic has not made any guarantees to me as to the results of treatments and 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 or treatment, and/or anticipated results of treatment.***

***Financial Agreement***
***I understand and agree to pay my co-insurance or co-payment at the time of service and all charges for services rendered that may not be covered by my insurance carrier(s). I understand that I may receive a bill from Access Medical Clinics and I am obligated to pay this bill for services rendered. Access Medical Clinics reserve the right to charge a Late Payment Fee and/or a Returned Check Fee.***

***If I elect to pay all charges myself, I will inform this clinic prior to receiving service.***

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

***Disclosure of Information for Payment Purpose***
***I understand my medical information will be sent to my insurance carrier for billing purposes for any treatment I may receive at this clinic 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 inform this clinic of my payment before the services provided. I also understand that if I fail to pay for the services, the information will be sent to my insurance company.***

***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 this clinic not use or share my information, I may submit a written request for consideration according to this clinic's Notice of Privacy Practices.***

***Non-Discrimination Policy***
***This clinic will 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.***

***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 clinic. 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 clinic for any services provided to me by this clinic.***

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

***Patient's Rights and Responsibilities***
***My signature below confirms that I read and understand the information on my Rights and Responsibilities as a patient.***

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***ACKNOWLEDGEMENT OF ACCESS MEDICAL CLINICS' NOTICE OF PRIVACY PRACTICES***

_____ ***I read and understand this clinic's Notice of Privacy Practices.***

_____ ***The patient or their duty authorized representative is unable to make this acknowledgement.***

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***MINORS OR INCAPACITATED PERSONS -- The patient is:***

_____ ***A minor _____ years of age.***

_____ ***Incapacitated and unable to sign for the following reason(s):***

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***I have read this content and I am the patient, or the patient's duty 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***