AUTHORIZATION AND CONDITIONS
FOR OUTPATIENT TREATMENT SERVICES

Print Patient Name: _____

Patient Date of Birth: _____

RESPECTFUL CONDUCT

It is expected that patients behave respectfully towards Wahiawā Center for Community Health (Wahiawā Health) personnel for the duration of their treatment. Any abusive or disrespectful behavior could result in dismissal from Wahiawā Health's care. Inappropriate behavior includes but is not limited to, offensive remarks (e.g., excessive profanity, racial remarks, sexual slurs), harassment, stalking, acts of aggression (e.g., threat of, or actual acts of violence, willful property damage), or possession of a weapon, alcohol, or illegal drugs on premises.

VALUABLES

As a patient, I am encouraged to leave personal items at home or give to a family member for safekeeping during appointments. Wahiawā Health is not liable for the loss or damage to any money, jewelry, documents, eyeglasses, dentures, hearing aids, cell phones, laptops, other personal electronic devices, or any other personal property.

CONSENT TO MEDICAL PROCEDURES

I consent to the customary procedures and therapies that may be performed while I am receiving outpatient services. These may include, but are not limited to, medication administration, laboratory procedures, telehealth services, or transfer to hospital services under the general and special instructions of my provider. I acknowledge that no guarantees have been made to me regarding the result of examination or treatment in this health center.

DISPUTE RESOLUTION

I agree that any dispute (including personal injury claims) related to healthcare services rendered by Wahiawā Health is subject to the exclusive jurisdiction of the appropriate court in the state where the provider of the disputed services is physically located when the services are rendered and the law of that state. Any state court action must be in the county where the provider of the disputed services is physically located when services are rendered. I understand that these agreements also apply to my legal representatives and next of kin.

USE OF CELL PHONE/ELECTRONIC DEVICES

I agree that Wahiawā Health, its affiliates and/or agents, may now, or in the future, use an automated telephone dialing system, and/or texting, to contact the cellular telephone number(s) that I provide to Wahiawā Health for future appointment reminders, no show notices, and/or payment purposes.

I understand that my healthcare provider, his or her assistants or receptionist, and any workforce member may need to contact me by telephone. In the event that I am not home, by my initials below I hereby expressly give my permission to leave the following information on an answering machine and/or my cellular phone, or with any other member of my household or by mail:

_____ Appointment reminders or rescheduling of appointments of Behavioral Health visits

_____ Scheduling of immediate follow up visits due to positive laboratory or diagnostic imaging results (results should only be given to the patient)

_____ Business need to contact me by cell/mobile phone or autodialed notification calls, including billing issues and the cell/mobile phone number provided is mine. My cellphone or mobile phone number is: (including area code) _____

_____ Please do not leave any messages on the answering machine, cell/mobile phone or with anyone else.

I agree that I have been made aware that once inside of the clinical area; I may not use a personal cellular phone or other device to video record or take photos of any staff, patients, or procedures. If I need photos, I will discuss this with my healthcare provider beforehand.

Patient's/Representative's Initials _____

LEGAL RELATIONSHIP BETWEEN HEALTH CENTER AND PROVIDERS

Not all providers, or others providing services to me (e.g., students, interns, fellows, and residents) are employees, representatives or agents of the health center. They have been granted the privilege of using or working with the Wahiawā Health for the care and treatment of their patients. Some are independent practitioners and not employees, representatives, or agents of the health center.

I understand that I am under the care and supervision of a provider and Wahiawā Health and its clinical staff are responsible for carrying out my provider's instructions. My provider is responsible for obtaining my informed consent, when required, for medical treatment, therapeutic procedures, or services provided to me under my provider's general and special instructions.

FINANCIAL AGREEMENT

I agree to promptly pay all bills in accordance with the charges listed in Wahiawā Health's charge description master and, when applicable, the health center's sliding fee scale and any discount payment policies based on state and federal laws. If any account is referred to an attorney or collection agency for collection, I will pay actual attorneys' fees and collection expenses. All delinquent accounts shall bear interest at the legal rate, unless prohibited by law.

ASSIGNMENT OF ALL RIGHTS AND BENEFITS

I irrevocably assign and transfer to the center all rights, benefits, and any other interest in connection with any insurance plan, health benefit plan, or other source of payment for my care. This assignment shall include assigning and authorizing direct payment to the center of all insurance and health plan benefits payable for these outpatient services. I agree that the insurer or plan's payment to the center pursuant to this authorization shall discharge its obligations to the extent of such payment. I understand that I am financially responsible for charges not paid accordingly to this assignment, to the extent permitted by state and federal law. I agree to cooperate with, and take all steps reasonably requested by, this center to perfect, confirm, or validate this assignment.

HEALTH PLAN CONTRACTS

Wahiawā Health maintains a list of health plans with which it contracts with in the state of Hawai'i. A list of such plans is available upon request. We do not contract with out of state or international health plans. Therefore, at the time of service, you may request an estimate of charges. Once services are rendered, you are obligated to pay for services received. Based on level of care and treatment provided, you may receive a statement for additional charges once final reconciliation occurs. It is my responsibility to determine if the center providing services to me contracts with my current health plan. It is my responsibility to know the coverage (co-payments, covered benefits) offered by my individual health plan.

Most insurance companies require provision of clinical diagnoses and information about the location, date, and duration/time of sessions. Sometimes additional clinical information may be requested, including but not limited to, treatment plans, progress notes, summaries, or the entire health record. This information will become part of the insurance company's files. By law, they are also required to maintain confidentiality of your information. By using your insurance coverage, you authorize Wahiawā Health to release such information to your insurance company. The information will be limited to the minimum necessary for the company to reimburse for the services you received.

CONTACT OUTSIDE OF SESSIONS

Policies regarding contact outside of Behavioral Health appointments assure the security and confidentiality of your information and are consistent with professional ethics and the law.

Phone Communications

Behavioral Health providers are often not immediately available by telephone. When unavailable during normal clinic hours, you can leave a message with the front desk staff or confidential voicemail. Every effort will be made to return your call within 48 hours. If you are experiencing a crisis, please do not leave a message. Instead, go to the nearest emergency room, dial 911, or call the crisis line at (808) 832-3100. Behavioral health providers do not accept e-mails or text messages regarding clinical matters.

Social Media

The Behavioral Health providers at Wahiawā Health do not connect with any patients through any social media platforms. These types of social contacts can create significant security risks for you and can affect your treatment.

Web Searches

Wahiawā Health will not use web searches to gather information about you without your permission, as this violates your privacy rights. During this time of advanced technology, there are vast amounts of information available about individuals on the internet. We ask that you respect the privacy of our Behavioral Health team by not accessing information online about any staff members, as the information may be inaccurate and can impact your professional relationship with your providers.

PROFESSIONAL RECORDS

The law and standards of the Behavioral Health professions require that we maintain treatment records of the services you receive. You are entitled to receive a copy of your records if necessary, unless seeing the records would be emotionally damaging; if this is the case, another Behavioral Health professional can review them with you to help you determine the need for access to your records. Your treatment record contains professional notes and can be misinterpreted and/or upsetting to untrained readers. It is highly recommended that if you need your treatment records, you request a summary as an alternative. You may be charged a fee for preparing copies of records or any professional time spent in responding to information requests.

CONFIDENTIALITY

Federal and state law protects the privacy of all communications between a patient and provider. In most situations, your Protected Health Information (PHI) can only be released to others if you sign a written authorization form that meets certain legal requirements imposed by the Health Insurance Portability and Accountability Act (HIPAA). Please inform your provider if you have any questions or concerns regarding confidentiality. Below is a description of some of the exceptions in which Wahiawā Health is permitted or required to disclose information without your consent or authorization.

Suspected Abuse or Neglect

There are some situations in which we are legally obligated to take action to protect others from harm, even if there is a need to reveal some information about a patient's treatment. Hawaiʻi has mandated reporting laws that require healthcare professionals to report any suspected or confirmed child, elderly, or disabled person abuse or neglect to the appropriate state agency.

Harm to Self or Others

In the rare event that this type of situation occurs, your provider will make every attempt to fully discuss this with you before taking any action. If you present a clear and imminent risk to harm yourself or others, we are required to take protective actions which may include but is not limited to, seeking hospitalization, contacting law enforcement, and/or contacting family members or others who can provide protection.

Legal Proceedings

In most legal proceedings, you have the right to prevent your provider from disclosing any information about your treatment. However, a court may order providers to release information, records, and/or testimony in some legal proceedings, and your provider may need to comply with the valid court order.

Professional Consultation

It may be helpful to consult other professionals about your care at times. During a consultation, every effort will be taken to avoid revealing information that could personally identify you as the patient. The consultant is also legally bound to keep the information confidential. You may not be informed about these consultations, unless it is essential for your treatment process.

Business Associates

The law requires Wahiawa Health to have formal business associate agreements with certain companies who may come into contact with patient information, such as companies who provide billing and claims processing, practice management software, legal consultation, IT support, and encrypted e-mail. Upon your request, you can receive the names of these businesses. The business associate agreements with these companies indicate their agreement to maintain the confidentiality of your information as required by law or as allowed in the contract.

I certify that I have read the foregoing and received a copy thereof, at my request. I verify that I am the patient, the patient's legal representative, or am otherwise authorized by the patient to sign the above and accept its terms on his/her behalf. This consent shall remain in effect until revoked or amended in writing.

Date: _____ Time: _____ AM/PM

Signature: _____
(Patient/Legal Representative)

If signed by someone other than patient, indicate relationship: _____

Print Name: _____
(Legal Representative)

Signature: _____
(Witness)

Print Name: _____
(Witness)