AUTHORIZATION AND CONDITIONS FOR OUTPATIENT TREATMENT SERVICES

Print Patient Name: _____

Patient Date of Birth: _____

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.

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.

GOOD FAITH ESTIMATE

Under the law, health care providers need to give patients who don't have insurance or who are not using their health insurance coverage an estimate of the bill for medical and/or dental items and services.

You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like appointment cost, medical tests, prescription drugs, and equipment fees.

Make sure your health care provider gives you a Good Faith Estimate in writing at least one (1) business day before your medical service or item, if the service is scheduled at least three (3) days in advance. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.

If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.

Make sure to save a copy or picture of your Good Faith Estimate and the bill.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call (800) 985-3059.

Disclaimer: This Good Faith Estimate shows the costs of items and services that are reasonably expected for your health care needs for an item or service. The estimate is based on information known at the time the estimate was created. The Good Faith Estimate does not include any unknown or unexpected costs that may arise during treatment. You could be charged more if complications or special circumstances occur. If this happens, federal law allows you to dispute (appeal) the bill.

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 Hawaiʻi. 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, co-insurance, 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.

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)

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