KAISER PERMANENTE® **HAWAII REGION**

(Card imprint or write legibly)

M R #:

Name:

Sex/BD:

Consent and Conditions of Treatment and Payment

Date: MM|DD|YY (Birthdays require full year)
Time: Military (as required)

1. Consent to Treatment

I consent to health evaluations, physical examinations, and medical treatments as well as to all outpatient care, whether diagnostic or therapeutic provided or prescribed by physicians, mid-level providers, clinical staff or contracted medical providers of Kaiser Foundation Health Plan, Inc, and Hawaii Permanente Medical Group (collectively "Kaiser Permanente").

2. Non-Discrimination Policy

Kaiser Permanente will treat patients regardless of race, color, national origin, religion, sex, sexual orientation, marital status, veteran's status, age or disability.

3. Assignment of Insurance Benefits

I hereby authorize Kaiser Permanente to bill and assign my right to receive payment directly from my insurance carrier for any benefits or series of benefits covered and payable by my insurance carrier, as well as proceeds of claims resulting from the liability of third party(ies) or organization(s). I also understand that prior to receiving services from Kaiser Permanente I may choose to pay for services directly if I do not want my health information for that service to be provided to my insurance carrier or other third party payor(s).

Specify any such conditions and/or services here:

_____

4. Financial Agreement

I the undersigned, individually obligate myself to pay Kaiser Permanente the amounts incurred by the patient in accordance with the regular Kaiser Permanente rates and terms existing at the time of the patient's service. I understand that I will be responsible for charges not covered by the patient's health insurance carrier(s).

I will be expected to pay the patient's medical bill in full at the time of registration (check-in) or upon discharge immediately following the provision of medical services, diagnostic services and/or procedures, unless I have made other arrangements with Kaiser Permanente's financial department. Should the bill not be paid, (and I have not taken action to discuss concerns about any charges with Kaiser Permanente), I understand that the account and any of the patient's healthcare information necessary for collection of the bill will be referred and provided to an attorney or collection agency. I will be responsible for paying all attorneys' fees, court costs, and other legal fees and costs incurred in collecting payment, together with late fees and interest at the maximum allowable by law.

I have read and understand this form and I accept and agree to follow the conditions contained therein.

Signature: _____ **Signature Date** (MM|DD|YY)**:**_____ ___ ___

Print name* (if other than patient)**:** _____

Relationship to patient: ☐Patient/Self ☐Parent ☐Guardian ☐Legal Representative ☐Other _____

**If patient is a minor, unable to sign and/or is incompetent to give consent, relationship of person authorized to give consent (unless otherwise specified by law) must be indicated.*

This section for Kaiser Permanente use only

Date: _____ Comments: _____

Received/Witnessed by: _____ Dept/Loc: _____

(print name & sign)