UCERA

University Clinical, Education & Research Associates
677 Ala Moana Boulevard, Suite 1003 • Honolulu, H/96813-4100 • phone: (808) 469-4900 • fax: (808) 536-7315

1. Consent for Treatment

I wish to receive medical care and treatment at University Clinical, Education & Research Associates (UCERA). Accordingly, I consent to the procedures that may be performed during this office visit, including emergency treatment. I authorize consent to any of the following: imaging, laboratory procedures, other diagnostic procedures, medical or surgical treatment, or other clinical services that my physician, physician assistant, or nurse practitioner believes are advisable to evaluate or treat me, and to other services rendered under the general and special instructions of my physician.

I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that this office has not made any guarantees to me as to the results of treatments 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 of treatment, and/or anticipated results of treatment.

2. Disclosure of Information for Payment Purposes

I understand that my medical information will be sent to my insurance carrier for billing purposes for any treatment I may receive at this office 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 law, I may choose to pay out-of-pocket for certain services if I do not want my health information regarding those services to be provided to my insurance company. I agree to notify this office of my wishes regarding payment before these services are provided. I also understand that if I fail to pay in full for the services, the information will be sent to my insurance company.

3. Information to Other Providers

I understand that this facility may share my information electronically or on paper with other providers in the course of my treatment, for making arrangements for my continuing care, or upon request when seeking care from other providers. If I prefer that this medical facility not use or share my information, I may submit a written request for consideration per this facility's Notice of Privacy Practices.

4. Financial Agreement

I understand that I will receive a bill from UCERA. I understand and agree to pay all charges for services rendered and that I am obligated to pay for services in accordance with the regular rates and terms of UCERA. UCERA has a right to charge a Late Payment Fee and for a Returned Check Fee.

If I choose to pay all charges myself, I will notify this office prior to receiving services.

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

5. Medicare Coverage

I certify that the information I have 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 UCERA. 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 UCERA for any services provided in this office.

6. Assignment of Benefits

I hereby authorize assignment of the medical insurance benefits I am due to UCERA for application to bills for medical services and supplies received. I further authorize UCERA to receive direct payment from all such benefit payments. I agree to remain responsible and liable for payments of all amounts due UCERA and not received from my insurance carrier(s). I understand UCERA is submitting claims on my behalf as a courtesy. I shall not revoke this assignment for any reason.

7. Patient's Rights and Responsibilities

My signature below confirms that I have received the information on my Rights and Responsibilities as a patient and I have received a copy of this facility's NOTICE OF PRIVACY PRACTICES.

MINORS OR INCAPACITATED PERSONS- The patient is (please check & complete):

- ☐ A minor years of age.
- ☐ Incapacitated and unable to sign for the following reason(s):_____

I have read this consent, received a copy of this facility's Notice of Privacy Practices, and am the patient or the patient's duly 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.

_____ _____ _____

Patient or Representative's Signature Print Name Date

REPRESENTATIVE: Please describe your authority to act on behalf of the patient:_____