TERMS AND CONDITIONS OF SERVICE
CONSENT FOR TREATMENT
Medical Services Agreement – Read Carefully Before Signing

1. **UHP:** UniversityClinical, Education & Research Associates dba University Health Partners of Hawai'i ("UHP") is a non-profit 501(c)(3) corporation affiliated with the University of Hawai'i, including its John A. Burns School of Medicine, and is comprised of its outpatient clinic locations, inpatient services, and telemedicine program.
2. **TEACHING, RESEARCH, AND HEALTHCARE INSTITUTION:** Because of its affiliation with the University of Hawaii, including its John A. Burns School of Medicine, UHP providers perform teaching, research, and healthcare activities.
    a. **Teaching activities.** I understand that residents, interns, medical students, students of ancillary healthcare professions (for example, nursing), post-graduate fellows, and other learners and trainees may observe, examine, treat, and participate in my care at a UHP location or service under the supervision of the attending physician as part of an approved medical education program.
    b. **Research activities.** I also understand that a University of Hawaii or other institutional review board and a University of Hawaii privacy board approve human subjects research projects in accordance with state and federal law. I understand that I may be contacted and asked to participate in research studies, but I am under no obligation to participate. My decision whether to participate or not will not affect my ability to obtain medical care.
3. **CONSENT FOR TREATMENT:** I wish to receive medical care and treatment at a UHP location or service. 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. In addition, I am aware the practice of medicine and surgery is not an exact science. I acknowledge that UHP 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 or other provider any questions that I may have about my diagnosis, treatment, risks or complications, alternative forms of treatment, and/or anticipated results of treatment.
4. **CONSENT FOR COMMUNICATIONS:** I understand that if I email, text, video chat, cell phone, or facsimile UHP physicians and others involved in my care that I am providing consent for them to respond to me using the same method I used, even if the messages contain confidential information. I understand that texting and email are not secure communication methods; for example, unencrypted messages could be intercepted. As such, I expressly waive the UHP provider's obligation to guarantee confidentiality with respect to such correspondence using such means of communication. I acknowledge that all such communications may become part of my medical records.
5. **USE OF MEDICAL INFORMATION:** I understand that my medical information, photographs, and/or video in any form may be used for other UHP purposes, such as quality improvement, patient safety, and education.
6. **RELEASE OF MEDICAL INFORMATION TO OTHERS:** UHP will obtain my written authorization to release information about my medical treatment, except in those circumstances where UHP is permitted or required by law to release information (see UHP's **Notice of Privacy Practices** for a description of the specific circumstances under which UHP may release this information). For example, UHP may release a copy of my

patient records to health care providers, health plans, governmental agencies, and workers' compensation carriers. Additional detail is provided below.

a. **To health care providers.** I understand that UHP may share my information electronically or on paper with health care 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 UHP not use or share my information, I may submit a written request for consideration per UHP's **Notice of Privacy Practices**.

b. **To my insurance carrier.** I understand that my medical information will be sent to my insurance carrier for billing purposes for any treatment I may receive at this UHP location, 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 carrier. I agree to notify UHP of my wishes regarding payment before these services are provided. I also understand that if I fail to pay in full for these services, my health information will be sent to my insurance carrier(s).

7. **FINANCIAL AGREEMENT:** I understand that I may receive a bill from UHP. (Most who sign this form will receive a bill; under limited circumstances some will not receive a bill.) 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 UHP. UHP reserves the right to charge a Late Payment Fee and/or a Returned Check Fee.

8. **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 coverage effective dates and Medicare claim number to UHP. 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 for UHP for any services provided by UHP.

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

10. **ACKNOWLEDGMENT OF RECEIPT:** I have read, agreed to, and received a copy of the following:

    a. **This TERMS AND CONDITIONS OF SERVICE**

    b. **NOTICE OF PRIVACY PRACTICES**

    c. **PATIENT RIGHTS AND RESPONSIBILITIES**

I have read this TERMS AND CONDITIONS OF SERVICE agreement and I 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 the terms in this agreement until I revoke my agreement, consent, or authorization in writing to UHP, or until one year since the last date of service.

Patient is a: ☐ minor _____ years of age ☐ incapacitated and unable to sign

Patient or Authorized Representative Signature	Print Name	Date
Witness Signature (If Patient Unable to Sign)	Print Name	Date