



THE QUEEN'S MEDICAL CENTER

CONSENT TO TREATMENT AND TERMS AND CONDITIONS OF SERVICE

Inpatient/Emergency/Surgical

NON-DISCRIMINATION POLICY - The Queen's Medical Center (QMC) will admit and treat patients regardless of race, color, national origin, religion, sex, sexual orientation, marital status, veteran's status, age or disability.

CONSENT TO TREATMENT - I authorize and consent to the medical care and treatment provided during my inpatient hospitalization or outpatient visit at QMC that my treating physicians and medical providers order for the diagnosis and/or treatment of my injury or illness. Such treatment may include the following: examination and evaluation, diagnostic procedures or tests, therapeutic procedures, medical treatment, surgical procedures, or other hospital or clinical services. I understand that the evaluation and treatment of my medical condition may require consultation with a physician or other healthcare provider using video conferencing (telemedicine) technologies. I understand I may be photographed or videotaped to document my medical condition and/or treatment, or for quality review purposes.

I am aware that the practice of medicine and surgery is not an exact science. I acknowledge that QMC has not made any guarantees to me as to the results of treatments or examinations. I am also aware that I should ask my physicians any questions that I may have about my diagnosis, treatment, risks or complications, alternative forms of treatment, and/or anticipated results of treatment. I understand that any requests or restrictions related to my treatment, and results of my treatment, must be discussed with my physicians.

I understand that if my stay is extended, I may be transferred to an off-site location operated by QMC. The off-site location will not have a Doctor of Medicine or a doctor of osteopathy present 24 hours a day/ 7 days a week. If my medical condition changes requiring higher level of care, I understand that my physician may decide to transfer me back to QMC Punchbowl; provided, however, that if I develop an emergency medical condition at an off-site location, 911 EMS will respond and I may be transferred to QMC Punchbowl prior to notification to my physicians.

LEGAL RELATIONSHIP BETWEEN INDEPENDENT HEALTHCARE PROFESSIONALS, INCLUDING PHYSICIANS, AND QMC -

Many physicians and certain other healthcare professionals providing medical services to me at QMC are independent contractors who are not employees or agents of QMC. These independent providers use their own clinical judgment in deciding how best to care for me and are therefore responsible for their own acts or omissions and may not create any liability on the part of QMC. QMC staff, including nurses and technicians, carry out the orders and instructions of the independent providers. Independent providers include my private physician(s), surgeon(s), anesthesiologists, and some intensivists as well as members of medical groups providing such services as emergency care (The Emergency Group, Inc.), interpretation of x-ray, CT and MRI scans and other diagnostic images (Radiology Associates), interpretation of PET scans (Medical Imaging, Inc.) and pathology services (Hawaii Pathologists Laboratory). I acknowledge that QMC bills only for charges incurred for hospital facilities and services, while the independent providers will generally bill me separately for their professional services, and I agree to make separate arrangements for paying them.

QMC BADGES, CLOTHING AND ADVERTISING - Badges and gowns worn by physicians, nurses, and other personnel are for security purposes only, and have no effect on the legal relationship between physicians and QMC. Advertising by QMC is intended to provide general information on the services available. All patients should discuss their care with their attending physician. Advertising by QMC is not intended to, nor does it affect the legal relationship between physicians and QMC.

PATIENT RIGHTS & RESPONSIBILITIES - My signature below will confirm that I have been given either (1) A copy of the "Patient Rights and Responsibilities"; or (2) "A Matter of Rights - A Guide To Your Rights and Responsibilities as a Resident" (both the written and verbal information).

NOTICE OF PRIVACY PRACTICES - My signature below will confirm that I have been given a copy of The Queen's Health Systems Affiliated Covered Entity Notice of Privacy Practices.

GENERAL DUTY NURSING ONLY - I understand that it is the standard practice of QMC to provide general duty nursing care. If I need or desire more nursing services I will be responsible for obtaining and paying for these extra services.

VALUABLES POLICY (Inpatient Only) - Patients are discouraged from bringing their valuables and other personal property into QMC. If I am unable to send valuables home, QMC, at my request, will store my valuables. I agree that total liability for loss or damage to such property stored by QMC is limited to \$250.00 per patient. I agree that QMC will not be responsible for any loss or damage to any personal property kept in my possession. I agree to place my personal belongings in a safe place, which includes, as applicable, labeled, protective containers for items such as hearing aids and dentures that I am not using at the time.

FINANCIAL AGREEMENT - I understand that I am responsible for paying my QMC bill in full within 30 days (or longer if required by law), unless I make other arrangements with the QMC Business Office prior to discharge. I also agree to these additional terms:

LATE PAYMENT CHARGE - A late payment charge of 1% per month, calculated at simple interest, may be assessed on all accounts not paid in full within 30 days (or longer if required by law).

COLLECTION - If the bill is not paid in full within 30 days (or longer if required by law) I understand that QMC may refer the matter to an attorney and/or collection agency and that I will be responsible for paying all legal fees and other costs incurred to collect my bill.

IF I HAVE MEDICARE/MEDICAID COVERAGE - I certify that the information given by me in applying for payment under Medicare/Medicaid is correct. I understand that the Social Security Administration may release information on my Medicare effective dates and Medicare claim number to QMC. I request that payment of benefits be made to QMC on my behalf. I consent to the release of my medical and other information related to Medicare/Medicaid coverage as needed for payment of this claim and related claims.

IF I HAVE HEALTH INSURANCE BENEFITS - I understand that I am responsible for paying all usual and customary charges for the services and items provided to me, unless my health insurance carrier has a contract with QMC and QMC has agreed to look to my insurance carrier for payment under that contract. I understand that even if I am eligible for benefits under a health care benefit plan, my insurance carrier may determine that one or more services or items is not a covered benefit under my benefit plan. If my insurance plan determines that a service or item provided by QMC to me is not a covered benefit under my health care benefit plan, I hereby authorize QMC to pursue payment from my insurer for the non-covered service or item on my behalf. If QMC does not have a contract with my health insurance carrier, I hereby irrevocably offer to assign my insurance benefits to QMC toward payment of my bill. I understand that QMC may accept this offer without notice to me, and, if QMC does so, QMC may submit a claim to the insurance carrier, and, at QMC's option, QMC may submit appeals and take all legal steps to obtain payment from the insurance carrier I agree to cooperate with QMC in its efforts to collect from my insurance carrier, and to immediately pay over to QMC all insurance proceeds paid directly to me for my care at QMC, and I understand that I shall remain responsible to pay the amount due on my bill, provided that QMC shall apply any amount paid by my insurance carrier to the balance owed. **Please ask to speak to Patient Financial Counseling with any questions about these terms, usual and customary charges, cost estimates, payment policies, or insurance benefits.**

CONSENT TO COMMUNICATIONS - I consent to receive communication, including billing information, in any manner, including automated emails, voice mails, written statements, text messages, autodialed calls and pre-recorded messages. I understand that these communications could result in charges to me. I agree that if I provide(ed) a cell/mobile phone number to QMC, I am giving consent to receive non-marketing communications regarding my care and billing for such care.

RELEASE OF SUBSTANCE ABUSE TREATMENT INFORMATION - If my medical records for this admission and/or course of treatment/service contain any information related to my treatment in a federally funded substance abuse treatment program, I consent to release such health information for the purpose of treatment, for obtaining authorization or payment from my insurers and other payers and for other specific insurer/payer requirements, within the limits of the law. I understand that I may choose to pay for treatment, in which case my health information will not be provided to my insurance company, but that I must make arrangements for payment before services are provided (or if unable to do so at that time, no later than the time of my discharge) and that, if I fail to make payment within 30 days (or as otherwise agreed in writing), the health information may be disclosed to my insurance company.

EXPIRATION OF CONSENT (Outpatient Services Only) - I understand that my consent to the terms and conditions of treatment for outpatient services is effective for any outpatient services I receive at QMC for the period of one year from the date of my signature below.

I certify that I have read this Consent and that I am the patient, or the patient's authorized representative. On my own behalf (and on behalf of the patient) I accept and agree to be bound by the Consent, a copy of which will be made available upon request.

X _____ Date: _____ Time: _____ : _____ a.m./p.m.
Signature of Patient

X _____ Date: _____ Time: _____ : _____ a.m./p.m.
Signature of Patient's Representative

Relationship to Patient

X _____
Queen's Medical Center Representative