QUEEN'S
ISLAND URGENT CARE

Tel: (808)735-0007
Fax: (808)735-0021

Workers Compensation and No Fault Financial Policy

PATIENT NAME: _____DATE OF BIRTH: _____PATIENT ID #_____

Thank you for choosing Queen's Island Urgent Care for your medical care. We are committed to providing access to the highest quality of affordable health care. We ask that you carefully read the following and sign below to acknowledge your understanding and acceptance.

1) **Any patient** who presents to QIUC with a possible injury will fill out an injury form stating where, what, why and when the injury occurred. This information is required by your insurance company and without it they may refuse payment and you will be responsible for the entire bill.
2) **WORKMAN'S COMP**: If you have an injury which occurred while at work, QIUC will submit a claim on your behalf as a courtesy and seek payment for your services, from your employer's Workman's Compensation insurance carrier. At the time of visit, QIUC will require the following information:
   a) **Date of your injury, your employer's name, employer's address and phone number, the name of your supervisor or HR director**, and the **name of your employer's workman's compensation insurance carrier**. If you are not able to provide us with the name of the workman's compensation carrier at your first visit we ask that you obtain this information. ***If QIUC does not receive this information within two days from the date of your first visit, the patient may be responsible for the incurred charges and further services for the injury may be refused by QIUC***.
   b) It is the patient's responsibility to inform your employer of your injury. If you are unable to inform your employer before you are treated, it is imperative that you notify them immediately after your visit. If you do not file an injury report with your employer (WC-1) and provide a copy for our file, you will be responsible for the claim and we may refuse further service related to your injury.
   c) If you request that we submit a claim to your employer's worker's compensation insurance carrier, but your injury is determined to be non-work related, QIUC will submit a claim to your personal insurance payer, provided that we are in network and contracted with your plan. QIUC cannot change your chart's documentation once you have reported to QIUC staff that your injury was work related. If your claim is denied for any reason, or if your employer fails to timely file your claim, you will be held responsible for the full payment for the services rendered. If your claim is rejected due to errors in the information you provided, you will be responsible for all charges.
   d) If you have been treated previously for this injury by another physician or clinic, other than an emergency room visit, QIUC will not be able to assume care for your injury without a transfer of care approved by your adjuster.
   e) QIUC Workers Compensation Department is at (808)735-0007 option 3. If there is information needed to file a claim or added information regarding the claim, please contact QIUC immediately. We will update your claim information and make appropriate contact to ensure the claim is accurate.
3) **NO-FAULT**: If you were injured as a result of an automotive accident **which occurred in Hawaii,** QIUC will seek payment for your services from the no-fault insurance carrier of the **owner of the vehicle you were riding in**, regardless of who was at fault for the accident.
   a) If you are the vehicle owner, you are required to provide us a copy of your valid no-fault insurance card and your insurance claim number a check in. If you were not the owner of the vehicle, you are required to provide us the claim number and a copy of the police report within 48 hours of the accident. QIUC requires this information in order to submit a claim to your No Fault insurance carrier for your treatment. If you do not provide this info, you will be responsible for the entire cost of the services provided. Without proof of coverage and or benefits, the visit is payable in its entirety at time of service.
   b) In the event your No Fault carrier deems your claim non-covered due to exhausted PIP benefits, deductible, or if you are not eligible for payment under No Fault Law, QUIC may submit a claim to your personal insurance policy provided we are in network and contracted with your plan. When billing your medical insurance carrier, we are required by law to report on our claim submission that your injury was the result of an automotive accident. QIUC cannot change your chart's documentation once you have reported to QIUC staff that your injury was related to a motor vehicle accident. If your claim is denied for any reason, you will be held responsible for the full payment for the services rendered. If your claim is rejected due to errors in the information you provided, you will be responsible for all charges.
   c) If your automotive related injury occurred more than three months prior to the current of date of visit, QIUC requires a letter of authorization for medical services stating that benefits have not been exhausted from your claims adjuster.
4) **CARD ON FILE:** Patients are required to provide a debit or credit card to keep on file for any Work Comp or No Fault visit in the event a balance is assigned to Patient's Responsibility. This information is held confidentially according to the national security standards (PCI Standards) in the form of tokenization. Any patient balance assigned by the insurance policy will be automatically debited from the credit card token on file five (5) days after the first statement date. You will be sent one statement showcasing the account's balance for reference and personal record keeping. Payment notification and receipt will be emailed to the email address provided at registration.

Card Type: □ Visa □ MasterCard □ Amex □ Discover **Last 4 Digits on Card:** _____ **Cardholder Signature:** _____

I have read, understand, and agree to the guidelines outlined in this policy. Your parent or legal guardian must sign below, if you are under the age of 18.

Signature Required: _____ **Date:** _____

Parent/Legal Guardian Printed Name:_____ **Relationship to Patient:** _____

(Complete if signer is not patient)