Hawaii Holistic Health Network
33 W. Kamehameha Ave.
Kahului, HI 96732
Tel: 808-359-3336

Hawaii Holistic Health Network: Consent to treat agreement, Patient Policies, Procedures and Payment Agreements.

_____

Please Print: First Name, Last Name

_____

Signature

_____/_____/2024_____

Today's Date

Patient Policies, Consent to Treat, Privacy and Payment Agreement. - Please read**, initial, sign and date**. Mahalo.

_____This document constitutes informed consent, treatment policies, and financial agreements for examinations, chiropractic care, medical care, consultations, supportive opinions, and authorization to treat by any of the doctors or licensed therapists, assistants that associated with Hawaii Holistic Health Network.

Privacy Policy:

_____Any contact information acquired by our clinic will be used only for that individual's medical services and will be secured by all HIPAA security requirements. Medical information may be released by our facility only upon the patient filling out and signing a record request release at our office. By signing this form, you consent that: Our office has 30 days to acquire all of a patient's requested medical records for a patient or another health practitioner. Patients must be aware co-pay charges may apply for significant copy requests over five pages as regulated by state laws.

_____Any contact information acquired by our facility on our websites will not be sold. Our facility does reserve the right to contact patients using this contact information for purposes of new services offered, promotional events, emergency situations, and for our own research and surveys. Testimonials written or videos submitted may be used for our website and/or promotional purposes. Personal contact information will not be sold to any second parties affiliated with our websites.

New Patient and Treatment Policies

____ Safety for our patients is a priority. During your visit to our office, you will be required to wear a face mask that covers both your nose and mouth, wash and/or sanitize your hands and your temperature will be taken and COVID-19 related questions will be asked. Social distance of 6 feet or more will be required while inside and a limited number of patients will be allowed inside, you may be asked to wait outside. If a patient is coughing you may be asked to leave and come back at another time, including if you have a fever/temperature.

_____Patients will be expected to receive all services rendered by our facility during our normal business operative hours. If patients request services after-hours or outside our facility, our practitioners reserve the right to charge extra after-hours-fee to provide a service at the practitioner's discretion.

_____New patients diagnostic testing such as imaging (x-rays, MRI's, etc..) may be prescribed for achievement of immediate and optimal results (unless pregnant on case-by-case basis), you may be asked to attend workshops and/or educational events and schedule a Report of Findings (ROF) appointment after following their initial consultation and examination. Spouses and/or a support person will be asked to attend any workshops and/or educational events including the ROF to become educated alongside the patient during their treatment and rehabilitation time at our clinic. It is our goal to educate the patient and their accompanying family member/spouse/support person in order to partner with the patient and their Ohana (family) to help them attain optimal health and achieve their personal health goals.

_____The patients are responsible for keeping scheduled appointments, performing prescribed home rehabilitation, office rehabilitation, and may be sent to obtain a progress x-ray after 6-12 months of care.

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Print Name (last) _____(First)_____Signature_____Date_____/_____ / 2024

Non-compliance Policy:

_____Any patients who do not comply with our prescribed treatment plans must not expect to achieve their requested health goals, or experience symptom relief. If you do not follow prescribed care by the providers, the results may be unsatisfactory. Examples of non-compliance may include any patient being treated for a personal injury due to a motor vehicle accident or workman's compensation with gaps in care and/or continually missing scheduled appointments to include therapy, rehab or consultations.

_____These patients may be discharged from our practice and their insurance adjusters contacted and notified of the changes. You also may be responsible for any medical bills your insurance does not cover due to non-compliance.

Scheduling and Cancellation Policy, and No shows for appointments:

_____ We value everyone's time, especially times and the appointments slots are limited to limited spots available to seek care and treatments. These appointments time slots are reserved for patients needing the medical care. No -show for a scheduled Provider appointments will result in $65.00/sixty-five dollars charge fee. If the patient does not cancel prior to **24 hours** of their scheduled appointment they will be charged a fee.

Print Name on the Card: _____ Signature: _____given consent to charge for NO shows and less than 24 hours' notice for appointments cancelations. **Please circle what type of card.**

Credit Card to be kept on file**: Visa- Master Card- American Express- Discover**- _____ CHECK HERE FOR charge card on file. ___Initials

Card Number: _____ Expiration Date: _____ CVV: _____

Billing Street Address: _____ State: _____ Zip Code: _____

Payment Policies

_____ I understand and agree that all services rendered are charged directly to me and I am personally responsible for all payments, even if I have insurance. I understand Hawaii Holistic Health Network is out-of-network for certain insurances such as Medicare, Medicaid- (and other insurance companies; patients can request a list of the in-network insurances) and that I am responsible and will pay at time-of-service. If utilizing insurance, I understand that I will provide the facility copies of my ID, SS number, and insurance card for verification purposes or

_____By singing this agreement I agree and waive your right to submit any claims to any insurance for re-imbursement, and assign all reimbursement to Hawaii Holistic Health Network, and Doctor Rocco.

but are still responsible for payments that the insurance may not cover.

_____ All requests must be submitted in writing; you have agreed that there is at minimum a 30 day wait period depending on other requests (including but not limited to records) that other patients may have and it is first come first serve basis.

_____ I understand special discounts may apply when a zero balance is maintained. If I suspend or terminate my care and treatment, all individual fees for services rendered to me will be immediately due and payable (including any tax) and no discounts will be allowed, but individual fees may apply.

_____ I understand and agree that all payment plans for treatments must be arranged with the clinic and approved by the Provider. This includes but not limited to chiropractic care, rehab treatments, nutrition packages and any and all services rendered. If payment plans are arranged, interest will be determined by Hawaii Holistic Health Network. Payments are due at time of service unless otherwise agreed in writing.

_____ I understand and agree that if I prepay for any treatment plans and decide to terminate my care after you have started, there will be no refunds and individual charges may apply.

_____All care plans are nontransferable to anyone else. If terminated prior to using all additional services used will be charged at full price (non-discounted), this includes but not limited to all rehab therapies, adjustments, therapeutic exercises etc.

_____ I understand you can not to waive insurance deductibles and that they are due at time of service. Therefore, I agree to make appropriate payments. All patients are responsible for all services and payments. Even if we verify your insurance, that does NOT guarantee that insurance will pay for the services you received. Therefore, the patient is responsible for any and all outstanding balances.

All Insurances Including: Major Medical, Auto Accident, Workmen's Compensation, Personal Injury, etc. Payment Policies.

_____ I understand that health and accident policies are an arrangement between an insurance carrier and myself. As such, I will provide any necessary insurance policy numbers, claim information (such as adjusters names, fax numbers, phone numbers etc.) contact information for myself (or minors), SS numbers information and forms necessary for collection from the insurance company. Hawaii Holistic Health Network will assist me with reports and answer administrative questions; however, I am responsible for services received and open balance. The insurance carrier may bill and pay a portion but ultimately it is the patient's responsibility for any outstanding balances.

_____ We will bill your insurance for you, but ultimately you the patient or POA, legal guardian if minor is responsible for any and all outstanding balances.

_____ I do hereby give permanent and irrevocable lien to Hawaii Holistic Health Network for any and all settlement, claims, judgment, including the insurance companies for/ or verdict as a result of accident/illness/workmen's compensation and authorize my attorney/insurance carrier to directly pay Hawaii Holistic Health Network such sums as may be due and owing for services rendered to me. I also authorize the withholding of such sums from any settlement, claim, judgment, or verdict as may be necessary to protect Hawaii Holistic Health Network.

_____ I understand that all personal injury claims (i.e., car accident and workman's compensation) payments are due and payable at the time of service unless third party terms that apply are acceptable. I agree that I am responsible for any unpaid balances.

Print Name (Last) _____(First)_____ (Last Name Signature_____Date_____2024

Continue

_____ I understand that if I am currently or in the future receiving care for personal injury from a motor vehicle accident or workmen's compensation, I will have associated third party billing at our insurance rates and an additional service charge fee will be added. Billing procedures are done in conjunction with third party reimbursement to appropriately cover prolonged reimbursement periods for services rendered in personal injury cases and workmen's compensations cases.

_____ I will be given the option and privilege to pay for any services out of pocket if I do not wish to use third party insurance or an attorney. If you do not have an attorney payment and the insurance company pays you the patient directly, full payment is due in immediately three business days after you receive your settlement from the insurance company. A surcharge of 20% (twenty percent) of my total balance will be incurred each day after that third day if payment is not received in full.

Assignment of Benefits

_____I authorize _____ **Insurance Company Name** to pay electronically or/and mail checks directly to Hawaii Holistic Health Network or the providing doctor.

Patient Records, All Payments, Chiropractic Lien Agreement for All Patients

I, _____Print Your First and last Name

do hereby authorize Hawaii Holistic Health Network to furnish my attorney or insurance carrier with a full report of my case history, diagnosis, treatments, exams, and prognosis of myself in regard to my accident/workers compensation illness for the purposes of billing or sharing the medical needs necessary for reimbursement. **Also, IF Auto or Workmen's Comp, Date Injury began**: _____

_____ I hereby give a lien to Hawaii Holistic Health Network on any settlement, claim, judgment, or verdict as a result of the said accident/illness and authorize and direct you, my attorney/insurance carrier, to pay directly to Hawaii Holistic Health Network Clinic such sums as may be due and owing them for services rendered to me and to withhold such sums from such settlement, claim, judgment, or verdict as may be necessary to protect Hawaii Holistic Health Network, and reimburse within three business day from the day they are received.

_____ I fully understand that I am directly and fully responsible to Hawaii Holistic Health Network for all medical bills submitted by them for services rendered to me and this agreement is made solely for Hawaii Holistic Health Network additional protection and in consideration of my awaiting payment. I further understand that such payment is not contingent on any settlement, claim judgment, or verdict by which I may eventually recover said fee.

_____ In the event a settlement or judgment has been reached, payment is required three business days from the date of settlement is decided. An additional 20% will be added for each day to the total balance if arrangements have not been made in writing three business after the settlement has been paid to me or my attorney.

Attorney's Only Representing Patients at Hawaii Holistic Health Network

The undersigned, being attorney of record or authorized representative of the insurance carrier for the above patient does hereby acknowledge receipt of the above lien and does agree to honor the same to protect adequately said above named Hawaii Holistic Health Network lien.

Attorney Name (Please Print): _____

Attorney Signature: _____ Date: _____, 2024.

(Please date, sign, and return one copy to the Clinic. Keep one copy for your records)

Treatment and Consent Patient Policies Continued.

_____You understand that: This document constitutes informed consent, for treatment policies, and financial agreements for examinations, chiropractic care, medical care, consultations, massages, supportive opinions, and authorization to be treat by any of the doctors or licensed therapists or Chiropractic Assistants that associated with Hawaii Holistic Health Network. By signing below, you understand and agree that Doctor Rocco will put his hands on you, to examine your entire body and treat you for adjustments and other therapies, this cover Doctor Rocco and anyone else working in this office Hawaii Holistic Health Network as part of his health care team.

I, _____ have read and fully understand the above policies concerning exams,
Patient Name – Print full name
treatments, and payments. All questions pertaining to my care in this office have been answered to my complete satisfaction. I, therefore, accept care on this basis and give permission for the providers to treat, examine and put their hands on me if they need to adjust etc.

_____ _____/2024 _____
Patient Signature Date Witness

Complete below: if Patient is a Minor Child or patient has POA:

I, _____ (Name of Parent or legal guardian/POA) being the parent, or POA or legal guardian of minor, of patient or disable patient POA's:

***Print Patients full*: First Name _____Last Name: _____**I have read and fully understand the above terms of acceptance and hereby grant permission for my child. Or an adult who you have POA, or authorization to receive health care/ treatment

. **_____ _____/____/____ / 2024 _____**
Parent/Guardian/ or POA -Print your First & last Name Signature Date Witness