



## Race and Ethnicity

Race (check one of the following):

- American Indian or Alaska Native
- Native Hawaiian
- African American
- Asian
- Caucasian
- Hispanic
- Other Pacific Islander
- Other Race

Ethnicity (check one of the following):

- Hispanic or Latin
- Not Hispanic or Latin
- Prefer not to say

Language (check one of the following):

- English
- Other: \_\_\_\_\_

Translator needed?  Yes  No

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### For Minors Only: Responsible Party

Name of Responsible Party\* \_\_\_\_\_

Relationship to patient\* \_\_\_\_\_

Birthdate\* \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Primary Phone\* (\_\_\_\_) \_\_\_\_ - \_\_\_\_

Mailing Address\* \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip code \_\_\_\_\_  
(If different from patient's address)

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### AUTHORIZATION TO COMMUNICATE INFORMATION REGARDING MY CARE

Please complete if you would like to authorize disclosure of your records to specific individuals.

I authorize the persons listed below access to my protected health information:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

I authorize the persons listed above access to the information as authorized below (**please check all applicable**):

\_\_\_\_\_ Appointments (Scheduling, rescheduling, canceling, etc.)

\_\_\_\_\_ Billing and payment records

\_\_\_\_\_ Information regarding my ongoing care (Prescriptions, prior authorizations, physician's orders, etc.)

\*Unless otherwise revoked, this authorization will expire on the following date or event: \_\_\_\_\_. If a date or event is not specified, this authorization will expire one year from my date of signature below.

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I certify that the information provided is true and correct to the best of my knowledge and belief and I understand and agree that I have a continuing obligation to advise Hawaii Pacific Neuroscience, LLC if there is a change in circumstances.

\_\_\_\_\_  
**Patient or Guarantor (Print Name)**

\_\_\_\_\_  
**Patient or Guarantor Signature**

\_\_\_\_\_  
**Date**

## **Patient Financial Responsibility Agreement**

Thank you for choosing Hawaii Pacific Neuroscience, LLC. As a courtesy, we will file your insurance claims for you, however, in the event that your insurance company denies payment for any reason or has not paid within 60 days, you and/or guarantor will be responsible for any balance due. We are a medical care provider; our relationship is with the patient and not the insurance company.

**Insurance Claims/Payment:** It is important to report any changes regarding your insurance. Failure to inform us of a change may result in exceeding the time allowed to file a claim and you will be responsible for all charges. You are responsible for payment of any non-covered services, deductibles, or co-pays for services rendered and charged to you directly.

- **No Insurance:** Self pay rates are available contingent upon service or procedure being performed. Payment must be made in full at the time of service. Please speak with office staff for rates.
- **Kaiser Insurance Plans with Secondary Coverage:** We are an out-of-network provider with Kaiser. We require all correspondence and payment from Kaiser prior to accepting your secondary insurance. It is your responsibility to understand the coverage and benefits of your policy. If you have any questions in regards to your plan, contact your insurance company.
- **Worker's Compensation:** We require an adjuster-signed treatment plan approval from the Treating Physician before the office schedules an appointment. It is your responsibility to keep the office informed with the status of your claim. Should your insurance deny payment due to unrelated diagnosis, you will be responsible for the charges.
- **No Fault:** Please present your auto and health insurance cards. We will initially bill your auto policy until funds have exhausted. Should your insurance deny payment due to unrelated diagnosis, you will be responsible for the charges.

**Referral/Authorizations:** We are a specialty practice. Some insurances require an authorization from a Primary Care Provider (PCP and/or PCM) or authorization approved by insurance prior to visit and it is your responsibility to obtain one. If we do not have the appropriate forms on file, your care may be delayed or you will be financially responsible for all charges. HMO plans, VA, Medicaid are examples of these insurances.

**Clinical Research Appointment:** Procedures and appointments that are not included with Clinical Research will be billed under the patient and/or guarantor's insurance.

**Patient Account Charges and Statements:** Copays and/or any balance due on your account are requested at the time of your scheduled visit. If you have no insurance at the time of your visit, you must pay the minimum out-of-pocket cost at the time of check-in before being seen by our provider. Additional charges may be incurred and will be the patient and/or guarantor's responsibility. We accept cash, check, and credit card.

- **Collections:** If your account is over 90 days old with no payment activity, your account will be transferred to a collection agency. If applicable, you and/or guarantor are responsible for all related expenses incurred in the collection of the delinquent amount due. These may include attorney fees and/or other costs that Hawaii Pacific Neuroscience, LLC considers necessary to collect the delinquent amount due.

- **Returned Checks:** All returned checks will be subject to a \$25 insufficient funds fee and any bank fees incurred. In addition, you will also be required to pay any outstanding balance by your next scheduled visit. As a result, you may be placed on a cash/credit card only payment method for future appointments.

**No Show and Cancellation Policy and Charges:** *Please be aware of our policy regarding cancellations, no-shows, and reschedules. If cancelling, rescheduling or not showing for appointments becomes a habit, we reserve the right to transfer care back to your primary care physician.*

*To ensure a smooth experience for all of our patients, we require that you provide notice of any changes to your scheduled appointment at least the minimum notice period listed below.*

*If notice is not given within the specified timeframe, the following charges will apply:*

| Visit Type  | Timeframe | Fee      |
|---|-----------|----------|
| Office Visits   | 24 hours  | \$75.00  |
| Procedures<br>(EMG, Routine EEG, Infusion,<br>Injections) | 48 hours  | \$150.00 |
| BEAM EEG  | 48 hours  | \$200.00 |
| Sleep Studies   | 1 week    | \$200.00 |
| VEEG  | 1 week    | \$650.00 |

Preferred form of billing communications\*:  Paper  Electronic (email or text)

\*If left blank, electronic bills will be sent unless otherwise notified.

By signing below, I hereby acknowledge and agree to the above financial responsibility as the patient and/or guarantor. I understand that I am responsible for any charges incurred and agree to pay them as required within 30 days of receiving my billing statement.

**Patient/Guardian Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(PRINT NAME)

**Patient/Guardian Signature:** \_\_\_\_\_

## Consent to Release of Medical Information

Patient's Name: \_\_\_\_\_

DOB: \_\_\_\_\_

By signing this document, I acknowledge and agree that Hawaii Pacific Neuroscience is permitted to disclose/request my health information including copies of records as necessary to/from:

1. Any health insurance plan or company of billing service that provides insurance coverage for me for the purpose of payment of charges, as well as any workers' compensation, no fault or administrative proceeding for the purpose of evaluating my medical condition.
2. Any insurance company that provides liability insurance coverage for Hawaii Pacific Neuroscience to evaluate clinical performance.
3. Consulting and treating physicians, diagnostic facilities, labs, radiology/imaging, outpatient facilities and hospitals and other health providers for the purpose of continuity of care.
4. External sources (i.e. pharmacies), granting permission to the doctors and medical assistants view your prescription history.
5. Other organizations, permitting the release of medical data in order to adjudicate claims associated with the patient.

All medical information with no exceptions will be disclosed / requested as necessary to/from the above. I authorize faxing of information as necessary. This authorization shall cover the period of time from my first visit to my last visit and will end 1 year after the date of my last visit. I permit a copy of this authorization to be used in place of the original.

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Patient or Guarantor (PRINT NAME)

Patient or Guarantor Signature

Date