KAISER PERMANENTE® **HAWAII REGION**

(Card imprint or write legibly)

M R #: _____

Name: _____

Birthday: _____

Consent to Ambulatory Outpatient Treatment and Payment

Date: MM|DD|YY (Birthdays require full year)
Time: Military (as required)

1. Consent to Treatment

- I agree to receive my ambulatory outpatient care at Kaiser Permanente facilities as provided or ordered by doctors, nurses, assistants and other staff employed or contracted by Kaiser Foundation Health Plan, Inc., Kaiser Foundation Hospital and Hawaii Permanente Medical Group, Inc. (collectively "Kaiser Permanente").
- I understand that my care may include physical exams, evaluations, lab tests, x-rays, procedures, medicines, and other treatment or monitoring, that in my providers' judgment may be helpful to care for my injury or illness, facilitate my preventative care or address other medical concerns.

2. Non-Discrimination Policy

I understand that Kaiser Permanente will treat patients regardless of race, color, national origin, religion, sex, sexual orientation, marital status, veteran's status, age or disability.

3. Assignment of Insurance Benefits

I agree to have Kaiser Permanente receive payment from my insurance plan for the care I receive. The payments may come from a state or federal insurance plan (Medicare or Medicaid), another insurance plan or other third-party payor. I agree to cooperate and provide information as needed to establish my eligibility for such benefits.

4. Financial Agreement

- I understand payment for costs not covered by the patient's insurance or other third-party payor(s) is the responsibility of the patient or the patient's legal representative. This may include co-pays, deductibles, or costs for evaluations/treatment that are not included as an insurance benefit.
- I understand that if bills are not paid on time, the account may be sent to collections. If this happens, I understand that the patient or the patient's legal representative will have to pay for the cost of the collection and/or reasonable fees from the collection.
- If I have a credit balance or overpayment, it will be applied to any outstanding or unpaid balances on my account(s), before I receive a refund.

5. Consent Effective

I understand that this consent remains in effect until terminated in writing by me or until legal circumstances change such that a new consent is required.

6. Changes to Form

I understand that if I refuse to sign this form or make any changes to this form prior to services being provided it may keep me from getting care and services, except for emergency care/treatment.

I have read and understand this form and I accept and agree to follow the conditions contained therein.

Signature: _____ **Signature Date** (MM|DD|YY)**:** _____|_____|_____

Print name* (if other than patient)**:** _____

Relationship to patient (if other than patient)**:** _____

**If patient is a minor, unable to sign and/or is incompetent to give consent, relationship of person authorized to give consent (unless otherwise specified by law) must be indicated.*

This section for Kaiser Permanente use only

Date: ____|____|____ Comments: _____

Received by: _____ Dept/Loc: _____

(print name & sign)