Malama Pono
HEALTH CARE, LLC
Claudia Christman, M.D.

Consent for Treatment

I authorize and consent to medical care and treatment at Malama Pono Health Care (to include tests and procedures) which my treating physician(s) and medical provider(s) find to be necessary and which is given or performed at their direction. I understand that any requests or restrictions related to my treatment must be discussed with my physician.

Notice of Privacy Practice and Disclosure of Information

I have read and received the "Notice of Privacy Practices." I understand that my health information (including treatment I receive for Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS), mental health diagnoses, and/or drug, alcohol and other substance abuse may be disclosed for the purposes of treatment, for obtaining payment from my insurers and other payors and for other qualified health operations within the limits of the law. I understand that according to Hawaii law, I may choose to pay for services if I do not wish my health information to be provided to my insurance company. I agree to notify this medical facility about my wishes regarding payment before these services are provided and I understand that if I fail to pay for the services, the information will be sent to my insurance company.

Non-Discrimination Policy

This medical facility will treat patients within its capabilities regardless of color, race, national origin, religious beliefs, gender, sexual orientation, marital status, veteran status, age, political beliefs, or disability.

Financial Agreement (Assignment of Insurance Benefits and Payment):

I understand that I am responsible for paying my bill in full. PAYMENT IS REQUIRED AT THE TIME OF SERVICE (Cash, Mastercard, VISA, or local checks). There will be a $25 service charge for returned checks. Malama Pono Health Care may charge the full price for an appointment if I do not provide 24 hour notice of cancellation, or if I do not show up for my scheduled appointment. Should the account be referred to an attorney or collection agency for collection, I agree to pay any reasonable attorney fee, collection expenses and interest at the statutory rate on delinquent accounts, whether or not the account is referred to a collection agency.

After Hours Appointments/Emergencies:

I understand that Dr. Claudia Christman, M.D. and the Malama Pono Health Care staff ARE NOT available for On-Call or emergency medical services. For emergency medical services, call 911 or go to the nearest hospital.

I hereby acknowledge that I have received and reviewed a copy of the Notice of Privacy Practices. I certify that I have read this Consent and that I am the patient or the patient's authorized representative and I accept and agree to be bound by the Consent, a copy of which will be made available upon request.

_____ (check if patient is a Minor or incapacitated person)

_____ _____
Patient or Legal Representative Signature Date

_____ _____
Print Name Representative Relationship to Patient