Lisa Nguyen MD LLC

3660 Waialae Ave. #208
Honolulu, HI 96816

Family Medicine Center
409 Kilauea Avenue
Hilo, HI 96720

Tel: (850)888-8598
(808) 597-6805
Fax: (888)354-2480

Agreement to Terms and Conditions of Treatment

CONSTENT TO TREATMENT: I (or my authorized representative) authorize and consent to treatment rendered by LISA NGUYEN MD LLC, (including diagnostic procedures) whether it be recommended, orders or performed. In doing so I am bound by this agreement and its terms and conditions.

FINANCIAL AGREEMENT: I am fully responsible for paying Lisa Nguyen MD LLC for services rendered including any remaining charges not covered by my insurance company. I am responsible for paying all charges in full within 30 days (or longer if required by law). Co-payments are also expected at the appointment.

LATE PAYMENT: I may be subject to interest charged on the payments (1% per month simple interest) or any remaining balance that is overdue more than 30 days (or longer required by law).

COLLECTION: I may be reported to a collection agency if my account is more than 90 days past due and will then be responsible for any additional penalties and all additional costs incurred in collecting my bill (including lawyers' fees).

MEDICARE/MEDICAID COVERAGE: I certify that the insurance information provided by me is correct to the best of my knowledge. I authorize the release of information required to process claims made by Lisa Nguyen MD LLC for care rendered on my behalf. I understand that the Social Security Administration may release information on my Medicare effective dates and clean number to Lisa Nguyen MD LLC. I request that payment of benefits be made to Lisa Nguyen MD LLC on my behalf for the care I have received.

ASSIGNMENT OF INSURANCE BENEFITS AND PAYMENT: I understand that I am responsible for paying my bill in full. If I am entitled to any insurance benefits, I assign all of these benefits to Lisa Nguyen MD LLC toward payment of my bill and direct my insurance provider to pay these benefits to Lisa Nguyen MD LLC. Lisa Nguyen MD LLC will bill my insurance provider if I provide the appropriate information in a timely fashion.

SELF PAY. If I do not have medical insurance or lack outpatient behavioral health/mental health services coverage, I can pay for office visits prior to the visit. Please see Fee Schedule for update fees.

RELEASE OF SPECIALLY PROTECTED HEALTH INFORMATION. If my medical records contain any information related to the Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS), mental health diagnosis or treatment, and/or my enrollment in a federally funded substance abuse treatment program, I authorize release of such health information for the purpose of treatment, for payment by my insurer(s)/payor(s) and/or for other specific insurance/payor requirements, as governed by the law. I may choose to pay for treatment directly in which case my protected health information will not be released to my insurance provider; in this case I agree to make the payment prior to receiving services on the relevant visit date. If I fail to provide payment within 30 days of this visit date, I agree to release my health information to my insurance company for purposes of collecting payment on my account.

CONFIDENTIALITY: My medical information will not be shared with anyone without my prior written consent. My insurance company may already have my written consent to request information to determine the necessity of medical treatment or diagnostic procedures. Only the minimum necessary information will be disclosed by Lisa Nguyen MD LLC to my insurance company in this case. I will contact my insurance provider or review my agreement with my insurance provider to understand the limits of confidentiality imposed on my health information.

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PREGNANCY AND OTHER MEDICAL CONDITIONS. If I am pregnant or plan on becoming pregnant I must inform Lisa Nguyen MD LLC as soon as reasonably possible and by my next visit at the latest. If my medication regimen or my medical condition changes, I must inform Lisa Nguyen MD LLC as soon as reasonably possible and by the next visit at the latest. If I failed to inform Lisa Nguyen MD LLC of such information in a timely fashion, I will have violated the agreement with Lisa Nguyen MD LLC and would then be in breach of contract.

BREACH OF CONTRACT. I agree to the terms and conditions of this Agreement in some and in parts. If I fail to uphold my part in this Agreement I will have violated this Agreement and will be in breach of contract. My care with Lisa Nguyen MD LLC may then be terminated.

CERTIFICATION. I hereby certify I have read this Agreement with Lisa Nguyen MD LLC and that I am the patient seeking care or the patient's legal authorized representative. I freely and voluntarily accept the terms and conditions of this Agreement and agree to be bound by them without reservation while in the care of Lisa Nguyen MD LLC. A copy of this Agreement will be provided to be upon request.

Patient Name (PRINT)**:** ____

Patient Signature: ____

Date: ____________________

Patient's Representative or Caregiver if patient is a minor (PRINT)**:** _______________________________________

Representative or Caregiver if patient is a minor SIGNATURE: ____

Relationship to Patient: **____**