HAWAII INJURY
RECOVERY CENTER

Patient Policies

Please review and initial:

_____ **FINANCIAL RESPONSIBILITY:** The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

_____ You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

_____ I have read the above policy regarding my financial responsibility to Hawaii Injury Recovery Center (HIRC), for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to HIRC, the full and entire amount of bill incurred by me or the above named patient, or if applicable any amount due after payment has been made by my insurance carrier.

_____ I understand that if a: **Worker's Compensation** claim is denied of controverted, **No Fault** claim is exhausted, or **Third Party Liability** claim does not include medical coverage therefore, in order to continue care, incase of those circumstances or for any other reason, we require your **private insurance** be on file so that you will not be responsible for the full charges. Furthermore, without this essential information, we may be unable to continue care.

_____ **CO-PAY POLICY:** I understand some health insurance carriers require the patient to pay co-pays for services rendered. It is expected and appreciated at the time the service is rendered for the patients to pay at each visit.

_____ **CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION:** I hereby authorize HIRC, through its appropriate personnel, to perform or have performed upon me, or the below named patient, appropriate assessment and treatment procedures.

_____ I further authorize HIRC to release to appropriate agencies, any information acquired in the course of my or the below named patient's examination and treatment.

_____ **CANCELLATION/NO SHOW POLICY:** We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we request that you call at least 24 hours prior to cancel/reschedule your appointment, and if not, we reserve the right to charge you $20.00 for your missed appointment.

_____ I understand that if I no-show for two consecutive appointments, no show for a total of three appointments, or cancel for a total of four appointments, I may be discharged from care. HIRC will notify me in writing, via certified mail, if you are discharged from care.

Patient Name:_____ **Date:**_____

Patient/Parent/Guardian signature:_____
(If patient is under 18 years old, a signature is required by a parent or legal guardian)