AULIKE HEALTH PARTNERS LLC PATIENT AGREEMENT

_____

Patient Name (Please list all children, if applicable) Date(s) of Birth

I,_____, the parent/guardian of the above patient(s) have read and understand the following documents that were provided to me to review:

1. HIPAA Patient Acknowledgement
2. Informed Consent for Treatment
3. Medical Treatment Authorization
4. Insurance Authorization
5. Medicare Lifetime Authorization
6. Patient Financial Responsibility

_____

Signature Date

HIPAA PATIENT ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding your protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
2. Obtain payment from third-party payers.
3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your NOTICE OF PRIVACY PRACTICES, which contains a more complete description of the uses and disclosures of my health information.

I have been given the right to review such NOTICE OF PRIVACY PRACTICES prior to signing this consent.

I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this organization or refer to www.reispediatrics.com at any time to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this acknowledgment in writing at any time, except to the extent that you have taken action relying on this acknowledgement.

INFORMED CONSENT for AULIKE HEALTH PARTNERS LLC

Objectives in Counseling:
Here at Aulike Health Partners LLC, our main goal is to help you gain insight into the problems that impact your daily living, so you can better cope with them and function at the highest level possible.

We do this by helping you:

1. Increase personal awareness.
2. Identify personal treatment goals, reviewing, and revising when necessary.
3. Increase personal responsibility and acceptance to make changes necessary to attain your best outcome.
4. Promote psychological healing and emotional well-being.

Keep in mind, you are a vital part of your treatment. To receive the most benefit from treatment, you may be expected to complete questionnaires and/or do homework assignments. Please understand you may not achieve the best outcome if you do not follow-through with these, and other, assignments. We count on you to be our partner in progress, and you may be asked to help your clinician create an appropriate treatment plan.

Appointments:
Appointments are usually scheduled for 30-60 minutes.

Cancellations and Missed Appointments:
You will be billed for sessions that you cancel with less than 24 hours notice. You may leave us a message 24 hours a day. The first time you miss a session without calling to cancel, you will not be charged. However, you will be billed $75 for any future sessions missed without 24 hours notice.

Emergencies:
If the emergency is life threatening (dangerous to you or anyone else) CALL 911 or go to the nearest emergency room. If it is a non-life threatening emergency, you may call your clinician during normal business hours, and he/she will work to accommodate an emergency session with you, if possible.

Confidentiality:
Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality.
These situations include:

- Suspected abuse or neglect of a minor-under the age of 18, elderly person, or a disabled person.
- Sexual activity between minors. Sexual activity with a minor age 15 or younger or someone 5 years older, or sexual activity between a minor and someone over age 18, per Hawaii law.
- When your clinician believes you are in danger of harming yourself or another person or when there is a threat posed to National Security.
- If your clinician is ordered by a court to release information as part of a legal case or litigation or court case, etc.
- When your insurance company is involved, e.g. in filing a claim, insurance audits, case review or appeals, etc.
- In natural disasters whereby protected records may become exposed.
- When you have signed a release to allow the release of confidential or privileged information.
- When otherwise required by law.

In the event you disclose to your clinician that you or someone else is abusing a child or is engaging in sexual activity with a minor (see above), your clinician is required to contact the appropriate authorities, and your clinician is required by law to disclose the nature of the abuse.

In the event you disclose to your clinician that you intend to harm yourself or (others), your clinician is required to contact the proper authorities, and your clinician is required by law to disclose the nature of the intent.

Record Keeping:
A clinical chart is maintained describing your condition, your treatment, progress in treatment, dates & fees for sessions, and notes describing each therapy session. These records are marked confidential and may be shared with your providers at Reis Pediatrics LLC and other entities covered under HIPAA. Your records will not be released without your written consent to other entities except in those situations as outlined in the Confidentiality section above. You may receive a copy of your records if you make a formal written request to your clinician and pay a $50 retrieval fee. Please be advised that it may take up to 30-days to receive your records from the day your request is received. If your clinician determines it would not clinically be in your best interest to receive the complete records, a summary of the notes will be provided instead.

Court Involvement:
Your clinician will not appear in court for any reason, *including custody disputes*, unless ordered by the court to do so. Nor will your clinician write any letters to the court for divorce or custody litigation as our role as clinicians does not include recommendations to the court concerning custody or parenting issues. By signing this consent you are indicating you understand that your clinician will not appear in court unless court-ordered to do so or release records for a legal matter without a court order or unless considered ethically appropriate by your clinician to appear in court, with the written consent of the client(s).

MEDICAL TREATMENT AUTHORIZATION

I understand that the information that I have been given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes in any information or the medical status of the minor child referred to on the signed agreement form. I authorize **Aulike Health Partners LLC** to perform any and all forms of treatment, medication, and therapy with my informed consent in connection with the patient's diagnosis and treatment plan. I also authorize Aulike Health Partners LLC to perform or order any diagnostic procedure(s) and/or test(s) deemed appropriate to make a thorough diagnosis. I authorize **Aulike Health Partners LLC** to administer such treatment, as they may deem necessary for the patient's diagnosis and treatment. I certify that I have been made aware of the role and services offered by the clinician and I consent to care by such providers. I understand that these services are voluntary and that I have the right to refuse these services.

T**reatment of Minors:**
P**ermission to Treat a Minor (Under age 18):** In the event of an emergency and I cannot be contacted, I give my permission to **Aulike Health Partners LLC** to treat my child in their office or appropriate treatment facility as required by the events of that emergency situation.

Minors are defined to be individuals under the age of 18. However, in the state of Hawaii, minors ages 14-17 years of age are the privilege holders for treatment and must consent to treatment and the release of treatment information, even to their parents, with some exceptions under Hawaii law. If a parent/legal guardian is bringing a minor in for services who is under the age of 14, the consent of both parents or legal guardians is required by Aulike Health Partners LLC. If one parent has decision-making authority as noted in a court document, Aulike Health Partners LLC requires that the other parent be notified of treatment, at a minimum. Additional documentation of guardianship might need to be provided in certain circumstances such as divorce before treatment can begin. The confidences of minors will be kept, according to law; however, due to minors being under the legal care of an adult, some information outside the limits to confidentiality might need to be shared with the guardian to promote the health, welfare, and safety of the minor.

INSURANCE AUTHORIZATION

Assignment of Insurance Benefits: I hereby authorize payment of medical benefits directly to **Aulike Health Partners LLC**. I further authorize the release of any medical information necessary for processing the insurance claim and any referral necessary for the care of the patient. I permit a copy of this authorization to be as valid as the original. I understand that all costs not paid by the insurance will become my responsibility unless otherwise prohibited by state or federal regulations. **I understand that if I do not inform Aulike Health Partners LLC of changes in my insurance coverage within 30 days from the date of service that I may be responsible for any charges incurred due to a delay in timely submission of charges.**

MEDICARE LIFETIME AUTHORIZATION

If the patient is covered by Medicare/Medicaid, I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize any holder of medical information about the minor child named herein above to release to the Social Security Administration, it's agencies, intermediaries, or carriers, any information needed for this or a related Medicare claim. I request that the payment of authorized benefits be made on the patient's behalf I assign the benefit payable for physician services to **Aulike Health Partners LLC** or the organization furnishing the services or authorize such physician or organization to submit a claim to Medicare for payment to me. I also authorize **Aulike Health Partners LLC** or the organization to appeal any denial of benefits on the patient's behalf.

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Insurance Claims/Payment: As a courtesy, Reis Pediatrics 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 45 days, the parent(s) and/or guarantor will be responsible for any balance due. It is also the parent(s) and/or guarantor's responsibility to provide current insurance information, including the insurance subscriber number and mailing address, and to follow up on any benefit questions with the insurance carrier. **You are responsible for informing Aulike Health Partners LLC of changes in insurance coverage within 30 days from the date of service, you may be responsible for any charges incurred due to delay in timely submission of charges**. We must emphasize that we are a medical care provider; our relationship is with the patient and not the insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered.

Patient Account Charges and Statements: Co-Payment and/or any balance due on your account are requested at the time of your scheduled visit; we accept cash, check, and credit card. If you have no insurance plan at the time of your visit you will be required to pay 100% of the visit charges before being seen by our practice. You may contact our billing personnel to arrange and sign a monthly payment plan agreement if necessary. **Aulike Health Partners LLC** may impose a collection fee and interest charge of 1.5% per month on any unpaid balance. In addition, a billing charge of $5.00 may be charged for each statement a patient receives after the initial one.

Collections: If your account is over 90 days old with no payment activity, your account will be transferred to a collection agency. A $35.00 fee will be added to your account upon transfer. If applicable, the parent(s) or guarantor is responsible for all related expenses incurred in the collection of the delinquent amount due. These may include, but are not limited to, attorney's fees and/or other costs that Aulike Health Partners LLC considers necessary in order to collect the delinquent amount due. To avoid collections, please be sure to pay your co-pay/balance at the time of your visit or mail in your payments by the due date shown on your statement.

Returned Checks: All returned checks are subject to a $25.00 NSF fee and any bank fees incurred. In addition to the returned check, and the NSF fee & bank fees, 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.

Credit Card Payment Authorization: **(OPTIONAL):** We request that your credit card information be on file with us to process any outstanding balances on your account. Our billing specialist will notify you before any transaction and will mail a receipt to your billing address.