Doctors of Waikiki
Patient Rights and Responsibilities

Doctors of Waikiki observes and respects a patient's rights and responsibilities without regard to age, race, color, sex, national origin, religion, culture, physical or mental disability, personal values or belief systems.

You have the right to:

- Considerate, respectful and dignified care and respect for personal values, beliefs and preferences.
- Access to treatment without regard to race, ethnicity, national origin, color, creed/religion, sex, age, mental disability, or physical disability. Any treatment determinations based on a person's physical status or diagnosis will be made on the basis of medical evidence and treatment capability.
- Respect of personal privacy.
- Receive care in a safe and secure environment.
- Exercise your rights without being subjected to discrimination or reprisal.
- Know the identity of persons providing care, treatment or services and, upon request, be informed of the credentials of healthcare providers and, if applicable, the lack of malpractice coverage.
- Expect the center to disclose, when applicable, physician financial interests or ownership in the center.
- Receive assistance when requesting a change in primary or specialty physicians or dentists if other qualified physicians or dentists are available.
- Receive information about health status, diagnosis, the expected prognosis and expected outcomes of care, in terms that can be understood, before a treatment or a procedure is performed.
- Receive information about unanticipated outcomes of care.
- Receive information from the physician about any proposed treatment or procedure as needed in order to give or withhold informed consent.
- Participate in decisions about the care, treatment or services planned and to refuse care, treatment or services, in accordance with law and regulation.
- Be informed, or when appropriate, your representative be informed (as allowed under state law) of your rights in advance of furnishing or discontinuing patient care whenever possible.
- Receive information in a manner tailored to your level of understanding, including provision of interpretative assistance or assistive devices.
- Have family be involved in care, treatment, or services decisions to the extent permitted by you or your surrogate decision maker, in accordance with laws and regulations.
- Appropriate assessment and management of pain, information about pain, pain relief measures and participation in pain management decisions.
- Give or withhold informed consent to produce or use recordings, film, or other images for purposes other than care, and to request cessation of production of the recordings, films or other images at any time.
- Be informed of and permit or refuse any human experimentation or other research/educational projects affecting care or treatment.
- Confidentiality of all information pertaining to care and stay in the center, including medical records and, except as required by law the right to approve or refuse the release of your medical records.
- Access to and/or copies of your medical records within a reasonable time frame and the ability to request amendments to your medical records.
- Obtain information on disclosures of health information within a reasonable time frame.
- Have an advance directive, such as a living will or durable power of attorney for healthcare and be informed as to the center's policy regarding advance directives/living will. Expect the center to provide the state's official advance directive form if requested and where applicable.
- Obtain information concerning fees for services rendered and the center's payment policies.
- Be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.
- Be free from all forms of abuse or harassment.
- Expect the center to establish a process for prompt resolution of patients' grievances and to inform each patient whom to contact to file a grievance. Grievances/complaints and suggestions regarding treatment or care that is (or fails to be) furnished may be expressed at any time. Grievances may be lodged with the state agency directly using the contact information provided below.

You are responsible for:

- Being considerate of other patients and personnel and for assisting in the control of noise, smoking and other distractions.
- Respecting the property of others and the center.
- Identifying any patient safety concerns.
- Observing prescribed rules of the center during your stay and treatment.
- Providing a responsible adult to transport you home from the center and remain with you for 24 hours if required by your provider.
- Reporting whether you clearly understand the planned course of treatment and what is expected of you and asking questions when you do not understand your care, treatment, or service or what you are expected to do.
- Keeping appointments and, when unable to do so for any reason, notifying the center and physician.
- Providing caregivers with the most accurate and complete information regarding present complaints, past illnesses and hospitalizations, medications, unexpected changes in your condition or any other patient health matters.
- Promptly fulfilling your financial obligations to the center, including charges not covered by insurance. Submitting a request to the center for any overpayments made, dispute of charges and appeals.
- Payment to center for copies of the medical records you may request.
- Informing your providers about any living will, medical power of attorney, or other advance directive that could affect your care.

You may contact the following entities to express any concerns, complaints or grievances you may have:

CENTER	Alan I Wu, MD Co-Founder, Doctors of Waikiki
STATE AGENCY	HAWAII DEPARTMENT OF HEALTH OFFICE OF HEALTHCARE ASSURANCE 601 KAMOKILA BOULEVARD, ROOM 395 KAPOLEI, HI 96707 (808) 692-7420
MEDICARE	OFFICE OF THE MEDICARE BENEFICIARY OMBUDSMAN: www.cms.hhs.gov/center/ombudsman.asp
ACCREDITING ENTITY	The Joint Commission Office of Quality Monitoring One Renaissance Boulevard Oakbrook Terrace, Illinois 60181 800-994-6610 complaint@jointcommission.org

DOCTORS OF WAIKIKI

MRN #: _____

AUTHORIZATION FORM

PATIENT CONSENT FOR MEDICAL TREATMENT

I, or the patient's duly authorized representative, do hereby voluntarily consent to and authorize medical care and treatment by Doctors of Waikiki through its individual physicians, employees, and/or agents. This care and treatment encompass all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the healthcare provider at Doctors of Waikiki. This consent is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). I acknowledge that no guarantees have been made to me as to the result of treatments or examinations performed by the healthcare provider at Doctors of Waikiki.

HIPAA PRIVACY RULE

The HIPAA Privacy Rule permits a covered entity to disclose the protected health information (PHI) of an individual who has been infected with, or exposed to (e.g. COVID-19), with law enforcement, paramedics, other first responders, and public health authorities without the individual's HIPAA authorization; when the disclosure is needed to provide treatment. For example, HIPAA permits a covered entity, such as Doctors of Waikiki, to disclose PHI about an individual who tests positive for COVID-19 in accordance with state law requiring the reporting of confirmed or suspected cases of infectious disease to public health officials. This is to notify a public health authority in order to prevent or control spread of disease (such as the Centers for Disease Control and Prevention (CDC), or state public health departments) that is authorized by law to collect or receive PHI for the purpose of preventing or controlling disease, injury, or disability, including for public health surveillance, public health investigations, and public health interventions.

FINANCIAL RESPONSIBILITY STATEMENT

I, or the patient's duly authorized representative, am ultimately responsible for all payment obligations arising out of my treatment or care and guarantee payment for these services. If I am a recipient of a health insurance plan that Doctors of Waikiki is contracted with, I am responsible for deductibles, co-payments, co-insurance amounts, or any other patient responsibility indicated by my insurance carrier. I am responsible for knowing my insurance policy. For example, I will be responsible for any charges if any of the following apply: my health plan requires a prior authorization or referral by a Primary Care Physician (PCP) before receiving services, and you have not obtained such an authorization or referral; I receive services in excess of such authorization or referral; my health plan determines that the services I received are not medically necessary and/or not covered by my health insurance plan; my health plan coverage has lapsed or expired at the time I received services; I have chosen not to use my health plan coverage.

If I am a recipient of a health insurance plan that Doctors of Waikiki is not contracted with, which includes travel insurance and patients with no insurance, I am ultimately responsible for all payment obligations arising out of my treatment or care and guarantee payment for these services.

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I authorize the release or receipt of and disclosure of any and all medical information related to my treatment and care, to or from any other health care provider who may be of assistance in providing medical care and treatment for me, and/or assisting in any reimbursement or benefits to which I may be entitled.

I have read this form, or had it read to me, and I certify that I fully understand and accept its contents, my rights and responsibilities, unless noted.

_____ _____ _____

PATIENT'S NAME (PRINTED) PATIENT'S SIGNATURE DATE

Patient, _____, is a minor, or is unable to sign above because: _____

_____

_____ _____ _____ _____

PERSON GIVING CONSENT (PRINTED) PERSON GIVING CONSENT SIGNATURE DATE RELATIONSHIP TO PATIENT

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