Consent to and Conditions of Treatment | Payment Agreement

Consent to the Pacific Cancer Institute

1. I wish to receive medical care and treatment at the Cancer Institute of Maui, Bobby C. Baker, MD, Inc. Accordingly, I authorize and give consent to any x-ray, examination, laboratory procedures, diagnostic procedures or any other medical services rendered to me under the general and specific instructions of my attending physicians as may be determined by their professional judgment.

I am aware that I should ask my physician any questions that I may have about my diagnosis, treatment, risks or complications, alternative forms of treatment, and/or anticipated results of my treatment.

2. I recognize that the Cancer Institute of Maui, Bobby C. Baker, MD, Inc. participates with the medical professional schools. Therefore I give my consent for nursing students to participate in my care under appropriate supervision. This participation will include review of your Protected Healthcare Information.

General Nursing Duties

I understand that Bobby C. Baker, MD, Inc. provides only general nursing care in accordance with the standard practices of Bobby C. Baker, MD, Inc. If I need or desire more nursing services, such as continuous or special nursing care, it is agreed that I or my legal representative or my physician will be responsible for making arrangements for those extra services.

Consent to Photograph

I authorize Bobby C. Baker, MD, Inc. to photograph (including all forms of imaging) me, or any part of me for medical purposes deemed necessary by this facility or my physicians.

Non-Discrimination

Bobby C. Baker, MD, Inc. treats patients without regard to race, color, religion, ancestry, national origin or handicap.

Disclosure of Health Information

I understand that Bobby C. Baker, MD, Inc. may disclose my health information for the purposes of treatment, payment, quality assurance, outcomes assessment, competence or qualifications review of healthcare professionals, accreditation, licensing, or credentialing activities, health plan claims or healthcare record data analysis, provider clinical performance evaluations, utilization management, research, required audits or other qualified healthcare operations. I understand further that my records may contain entries or information relating to sexually transmitted diseases, including Human Immunodeficiency Virus (HIV) or psychiatric impairment, drug and alcohol abuse and other personal information.

Bobby C. Baker, MD, Inc., may disclose health information to physician(s) or referring physician(s), or others in order to coordinate my current care, to arrange transfers or the provision of other continuing care following the treatment from Bobby C. Baker, MD, Inc.

Assignment of Insurance Benefits

In the event the undersigned is entitled to insurance benefits of any type whatsoever arising out of any policy of insurance insuring patient or any other party liable to patient, said benefits are hereby assigned to Bobby C. Baker, MD, Inc. for application to the patient's bill, and it is agreed that Bobby C. Baker, MD, Inc. shall discharge the said insurance company of any and all obligations under the policy to the extent of such payment. The assignment of such benefits shall in no way obligate Bobby C. Baker, MD, Inc. to delay or relinquish its demand for direct payment from the patient of any portion of the outstanding balance.

Financial Agreement

The undersigned agrees, whether signing as an authorized representative or a patient, that in consideration of the services to be rendered to the patient, the patient is hereby individually obligated to pay the account of Bobby C. Baker, MD, Inc. or any portion that is not covered by ones insurance plan.

The Use of My Name

I understand that it is sometimes necessary to post/say my name for care and efficiency and to allow the health care team to locate me. I give my permission to have my name posted/said for these reasons.

The undersigned certifies that he/she understands the foregoing, and is the patient, or the patient's parent, next of kin, or authorized representative and is duly authorized to execute and accept its terms.

Signature: ______________________________ Date: ______________

Signature of Witness: ______________________________

If the patient is a minor or unable to sign, then his/her representative gives the above concent on the patients behalf.

Signature of Representative: ______________________ Relationship to Patient: __________