PATTI K.MURAKAMI ENDO, M.D.

DIPLOMATE AMERICAN BOARD OF DERMATOLOGY

PATIENT FINANCIAL RESPONSIBILITY

You agreeing to receive services at Patti K.M. Endo, M.D. implies a financial responsibility on your part.
This responsibility obligates you to payment in full of our fees. Please remember that an insurance contract is between the patient and his / her insurance company, not between provider and the insurance company. Insurance contracts obligate patients to pay co-pays and doctors to collect them. This office does not accept responsibility for collecting your insurance claim or for negotiating a disputed claim.

AT EVERY OFFICE VISIT, YOU ARE RESPONSIBLE TO PROVIDE:

- **PICTURE ID**
- **CURRENT INSURANCE CARD(S)**
- **NOTIFY US IF YOUR INSURANCE, ADDRESS OR PHONE NUMBER(S) CHANGE.** ***(You will need complete a new patient demographic form every time your contact information changes)***
- **OFFICE VISIT CO-PAY OR BALANCE DUE FROM PRIOR OFFICE VISITS**

- **Co-Payment, Deductibles and/or Co-Insurance-** It is the patient's responsibility to understand these terms as determined by your contract with your insurance carrier.
- **Referrals-** If your insurance requires a referral for services, it is the patient's responsibility to obtain one from the primary care physician PRIOR to the appointment. If no referral is received by our office prior to your appointment, we will need to reschedule your appointment until a referral is received. Dr. Endo is a specialist, and does require all new patients obtain a referral from their primary care physician to Dr. Endo.
- **Exclusion of Plan Benefit(s)-** Not all services are covered by all insurance contracts. If your insurance plan does not cover a service or procedure, you may be liable for full payment of the bill.
- **Private Pay/Self-Pay-** Dr. Endo is only accepting patients with active insurance benefits with carriers that she is a participating provider. She is not accepting Self-Pay/Cash patients.

PATIENT STATEMENTS/BILLING:

- Upon payment from your carrier, we will balance bill you for any remaining amount.
- Patient balances are due upon receipt of their statements.
- Responsibility for payment for services rendered to the child(ren) of divorced or separated parents' rests with the parent who seeks treatment. Any court ordered judgment must be between the individuals involved without including our facility. We will not send duplicate statements to separated parents.
- As well, patient's getting divorced/who are divorced; it is the patient seeking treatment who is responsible for payment. Any court ordered judgment must be between the individuals involved without including our facility.
- If you receive a statement that your insurance company has not paid for a claim, you should contact your insurance carrier for explanation of benefits and clarification.
- Accounts Past Due 90 days + may automatically be sent to collections if it is not paid in a timely manner, and our clinic may cease providing services to you. No further notices/phone calls will be made after 3rd statement is sent to the address you have provided on file.
- There will be a **$20.00 Return Check Fee** in the event your payment is returned unpaid by your financial institution.
- **Missed Appointment Policy:** In order to provide the best service to all of our patients, we require 24 hours advance notice if you are unable to keep your appointment. A **$40.00 Missed Appointment charge** may be assessed if your appointment is not cancelled within the required 24 hour time frame. **These charges are not payable by your insurance company and must be paid prior to making another appointment.** Patients may be dismissed from the practice if they "No-Show" to three (3) office appointments.

I HAVE READ THE ABOVE AND UNDERSTAND THE STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY
I understand that Dr. Endo is only accepting patients with active insurance benefits with carriers that she is a participating provider. She is not accepting Self-Pay/Cash.

_____ _____

Print Patient Name *Patient Signature* *Date*

_____ _____

Print Parent/Guardian/POA or Other Responsible Party Name *Parent/Guardian/POA or Other Responsible Party Signature*

1830 Wells Street, Suite #102 Wailuku, Hawaii 96793-2365
Telephone (808) 877-3635 FAX (808) 877-4363

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Acknowledgement of access to and/or receipt of Notice of Privacy Practices

Please initial in the box below that you acknowledge that you may request access to review, or request a copy of Dr. Endo's Notice of HIPAA Privacy Practices (available at the front desk, please ask the receptionist). ☐ Patient/Guardian/Parent/POA initial

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION

Patient Name:_____ Patient Date Of Birth: ____/____/____

FIRST NAME MIDDLE INITIAL LAST NAME MONTH DAY YEAR

****For protection of your personal health information, in order for us to discuss any billing, appointments, results or findings, etc., with anyone other than the patient, we are required to obtain written authorization. Please complete Section I (including names of the people you allow us to share your specific information) and the signature line below.**

****If you decline authorization to discuss your protected health/medical information with anyone but the patient, you may skip to Section II *check "decline", and then sign the signature line.**

I) **I authorize Patti K.M. Endo, M.D., and/or her staff, to discuss my selected Protected Health Information (PHI) with other individuals; i.e- children, grandparent, sibling, caregiver etc. *(Please check any/all boxes you authorize).***

Information may be shared with (must be completed if you want us to discuss with anyone other than patient):

1) **Name:** _____ **Relationship:** ☐ Parent/Guardian ☐ Spouse ☐ Other _____

☐ Appointment date/time ☐ Medications ☐ Summary of medical record ☐ Lab Test/Results ☐ Biopsy Results ☐ Billing

2) **Name:** _____ **Relationship:** ☐ Parent/Guardian ☐ Spouse ☐ Other _____

☐ Appointment date/time ☐ Medications ☐ Summary of medical record ☐ Lab Test/Results ☐ Biopsy Results ☐ Billing

3) **Name:** _____ **Relationship:** ☐ Parent/Guardian ☐ Spouse ☐ Other _____

☐ Appointment date/time ☐ Medications ☐ Summary of medical record ☐ Lab Test/Results ☐ Biopsy Results ☐ Billing

4) **Name:** _____ **Relationship:** ☐ Parent/Guardian ☐ Spouse ☐ Other _____

☐ Appointment date/time ☐ Medications ☐ Summary of medical record ☐ Lab Test/Results ☐ Biopsy Results ☐ Billing

5) **Name:** _____ **Relationship:** ☐ Parent/Guardian ☐ Spouse ☐ Other _____

☐ Appointment date/time ☐ Medications ☐ Summary of medical record ☐ Lab Test/Results ☐ Biopsy Results ☐ Billing

II) ☐ **DECLINE-(***Check box, only if you decline***).** Please do not discuss my information with anyone other than myself/patient. I may change my request at any time, either verbally or by written authorization.

III) Do you have an Advance HealthCare Directive/ Medical Care Directive or Power of Attorney? ☐ Yes ☐ No
If "Yes", please provide a copy, or we can make a copy, in office, for your patient chart.

This shall remain in effect from the date signed below (please check one):

☐ _____ Specify expiration date. ☐ NO EXPIRATION DATE

_____ _____ _____

Print Patient/Parent/Guardian/POA/ Other Responsible Party *Signature Patient/ Parent/Guardian/POA /Other Responsible Party* ***Date***

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