Consent Forms

HIPPA Consent

In April of 2003, new federal requirements regarding privacy of information for health care patients take effect. The Health Insurance Portability and Protection Act (HIPPA) requires that all medical providers, insurance companies and others, put in place controls to ensure that your personal medical information is safe. The Waterford Vein Institute of Hawaii requests that each patient sign this consent form which allows us to share protected health information with other physician offices, your hospital and insurance company. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent.

Authorization to Release Information to Family Members

Under HIPPA, we are not allowed to give information on test results and procedures unless patient permission is given. This consent form will allow Waterford Vein Institute of Hawaii to release your medical and billing information to family members listed in your chart.

Authorization to Leave Messages with Household Members/Answering Machine

The purpose of this consent is to give Waterford Vein of Hawaii permission to leave messages with members of your household or on your answering machine about appointment reminders, ultrasound or procedure results or to ask a patient to call regarding an issue or concern. At no time will a representative discuss your medical circumstances or condition without your consent.

Authorization to Release Health Information

As needed, we may request relevant medical records from any of your existing healthcare providers that may assist us in your evaluation and treatment.

Photography Consent

I understand that photographs or other digital other images may be recorded to document my care. I agree to have photographs taken for my records, as well as for use in medical, scientific, educational, and promotional purposes. I understand that Pacific Rim Cardiovascular / Waterford Vein Institute will retain the ownership rights to these photographs or digital images, but that I will be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner that will protect my privacy. I waive all my rights to any claims for payment or royalties.

Patient Responsibility for Payment Consent

All patients are responsible for their insurance deductible and co-pay amounts. If your insurance company determines that the procedure is not covered for any reason, you will also be responsible for the remaining charges. For those patients who do not have insurance, payment is due at the time of service via cash, check or charge (All major credit cards accepted. CareCredit financing options are also available.). If for any reason it becomes necessary to initiate collections proceedings, I understand I am responsible for the cost of all treatments received, as well as any and all legal or collection fees the Waterford Vein Institute of Hawaii incurs.

☐ Please check here if you agree to all of the above consents ☐ Please check here if you refuse any of the above consents

If you refuse, please list here: _____

You have the right to revoke any of these consents, in writing, except where we have already made disclosures in reliance on your prior consent.

Print Name: _____ **Date**: _____

Signature: _____**Date of Birth**: _____

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