

‘EKAHI HEALTH’S PAYMENT AND INSURANCE FINANCIAL POLICY

Thank you for choosing ‘Ekahi Health to be your provider of choice. We are committed to providing you with the highest quality affordable health care. Some of our patients have had questions regarding their insurance and individual payment responsibilities for the services we provide. We have developed this policy to answer those questions and to provide some basic information for any financial decisions that may arise during the course of your care. Please read this policy and feel free to ask any questions. We ask that you also sign below to acknowledge your understanding and acceptance. A copy will be provided to you upon your request.

- 1. FEE FOR SERVICE:** If you do not have insurance, you may still be seen at ‘Ekahi Health, however, you will be responsible for payment of all charges incurred. **Full payment will be due at the time of service.**
- 2. INSURANCE:** We participate with Medicare, Fed 87, UHA, HMAA, HMSA Akamai Advantage, and HMSA HMO & PPO. If your insurance is a HMO, it may require you to obtain a written referral from your primary doctor before we can see you. If you are insured under a plan we do not participate with, full payment will be expected for your visit at the time services are rendered. You will then be responsible for submitting your own claim to your insurance carrier for reimbursement. We encourage all of our patients to contact their insurance company prior to treatment to make sure that the visit will be covered at our facility. It is the patient’s responsibility to know his or her own insurance benefits.
- 3. PROOF OF INSURANCE:** All patients must complete our patient information form as well as any other required forms prior to being seen. If you are insured by a plan we participate with, you must provide a valid insurance card with your member ID and a **valid State ID, driver’s license, or passport**, which we will photocopy. Insurance carriers require us to ask you for your social security number so that we may verify your coverage. If you are unable to produce these IDs or we are unable to verify your identity or coverage, we will need to collect payment in full at the time of your visit.
- 4. CO-PAYMENTS AND DEDUCTIBLES:** Your medical insurance carrier requires that you pay a co-payment amount for your medical visits as well as satisfy a deductible amount before it will pay for your health visit. For your convenience, we accept **Hawaii State personal checks, cash, Visa, MasterCard, American Express and Discover Card**. A \$30 administrative fee as well as bank fees incurred will be assessed for each check or electronic transaction denied by your bank.
- 5. NON-BILLABLE AND NON-COVERED SERVICES:** Please be aware that some, and perhaps all, of the items or services you receive may not be a covered benefit under your insurance plan. Your insurance benefits are determined by the plan chosen by you and your employer and how much your employer pays for your coverage. It is your responsibility to contact your insurance

company if you have any questions or concerns. It is also your responsibility to pay in full at the time of service for any non-billable and non-covered items or services. This may include a re-swipe of your credit card if your co-payments and deductible amounts have already been paid when you first checked in.

6. **CLAIMS SUBMISSION:** It is our policy to submit your claim to your insurance company in a timely manner. The claims will be submitted by the provider that you see for your visit but may also be submitted under Dr. Kevin Lum, the medical director for 'Ekahi Health, for those claims submitted under the clinic. It is sometimes necessary for your insurance company, or our billing department, to contact you directly for information or assistance. It is your responsibility to comply with this request in a timely manner. Please understand that the balance of your account is your responsibility, whether your insurance company pays your claim or not. It is in all parties' best interest to cooperate in this matter. We ask you to review all correspondence carefully and contact your insurance company or us immediately with questions or concerns. If we do not receive full payment from your insurance company within 45 days from the date of submission, the entire balance owed may become your responsibility.
7. **COVERAGE CHANGES:** If you are a returning patient any your insurance coverage has changed, you must notify 'Ekahi Health at the time of your visit to ensure proper billing for your services. Any denials on insurance coverage will be the responsibility of the patient and full payment for the services rendered will need to be collected at the time of visit.
8. **NONPAYMENT:** As a courtesy, 'Ekahi Health will provide you with statements of your account. It is your responsibility to review these statements for accuracy and respond immediately to any and all requests for information and payment. If you discover an error, duplicate charge, or have any concerns about your bill, please contact us at 808-777-4001. A \$20 late fee will be applied to all open accounts past 30 days. Accounts past due of 90 days or higher are subject to collection action pursuant to the full extent of the law. Partial payments will not be accepted.
9. **ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:** We will enforce your privacy rights to the full extent of all local, state and federal laws and maintain the privacy of your personal health information. At your request, we will provide you with a Notice of Privacy Practice, which further describes this policy.
Medicare / Medicaid / Tricare Patient's Certification: I certify that the information given by me in applying for payment under Titles XVIII and XIX of the Social Security Act or in connection with any other government program is correct. I authorize any holder of medical, or other information, about me to release to the Social Security Administration, other intermediaries, or carriers of the State any information needed to process a claim for tis or any related service. I request that payment of authorized charges be made on my behalf directly to the facility for its charges and for any charges of physicians or other providers for whom the facility is authorized to bill in connection with its service.

Thank you for taking the time to review our financial policy. Please do not hesitate to ask any questions. Please notify the receptionist if you would like a copy of your signed Financial Policy.



'Ekahi Health Center
500 Ala Moana Blvd Suite 6-D
Honolulu, HI 96813
P: (808) 777-4000 | F: (808) 447-0571



NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: January 2020

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact our Compliance Officer:
Jade Wong

(808) 942-8108
1585 Kapiolani Blvd., Suite 1800
Honolulu, HI 96814

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by

- **'Ekahi Wellness**
- Our employees, staff, allied health professionals, temporary agency personnel, contracted services personnel, volunteers, residents, postgraduate fellows, medical students, students of other health care professions or educational programs at our facilities, independent contractors, and other authorized workforce who may need to access your information.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about you, your health, health status, and the health care and services you receive from **'Ekahi Wellness**. Your health information may include information created and received by **'Ekahi Wellness**, may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

- **Treatment.** We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, staff or other personnel who are involved in taking care of you and your health.



For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our organization may share information about you and disclose information to people who do not work for *'Ekahi Wellness* in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. We will request your permission before sharing health information with your family or friends unless you are unable to give permission to such disclosures due to your health condition.

- **Payment.** We may use and disclose health information about you so that the treatment and services you receive at *'Ekahi's Wellness* may be billed to and payment may be collected from you, an insurance company or third party.

For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will pay for the treatment.

- **Health Care Operations.** We may use and disclose health information about in order to run *'Ekahi Wellness* and make sure that you and our other patients receive quality care.

For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

We may also disclose your health information to health plans that provide you insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

As part of our healthcare operations, we coordinate with a health system called **'Ekahi Health System** and other health care providers in the community to better coordinate care, improve the quality of your health care services, and reduce health care costs. We may share your protected health information with **'Ekahi Health System** and other health care providers in the accountable care network for these purposes.

- **Business Associates:** We [may] contract with a number of business associates for the purchase of services and to assist us in providing treatment, payment and health care operations. For these business associates, we may disclose your protected health information to the extent necessary for the business associates to perform their jobs and functions as contracted and as we request. To protect your protected health information, the business associates must agree to safeguard the protected health information disclosed to them.



SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Abuse or neglect.** By law, we may disclose protected health information to the appropriate authority to report suspected child abuse or neglect or to identify suspected victims of abuse, neglect, or domestic violence.
- **Required by Law.** We will disclose health information about you when required to do so by federal, state or local law.
- **Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.
- **Organ and Tissue Donation.** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.
- **Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.
- **Disclosures to your employer or your employee organization.** If you are enrolled in a health plan through your employer or employee organization, we may share certain protected health information with them without your authorization, but only when allowed by law. For example, we may disclose your protected health information for a worker's compensation claim or to determine whether you are enrolled in the health plan or whether premiums have been paid on your behalf. For other purposes, such as for inquiries by your employer or employee organization on your behalf, we will obtain your authorization when necessary under applicable law.
- **Worker's Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
- **Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.



- **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
- **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.
- **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
- **Family and Friends.** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room or the wellness center during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick, for example, filled prescriptions, medical supplies, or X-rays.

- **Electronic Health Records and Health Information Exchanges.** *Ekahi Wellness* keeps records of your visits. Some of these records are in paper form, but most of your records are in an electronic form known as electronic health records. We share your records, and the health information they contain, electronically among our own facilities. For example, if you go to one of our locations for an urgent care matter, then that location's physicians would be able to access your health information to help make treatment decisions for you.

We may also share your health information electronically with other organizations through a Health Information Exchange (HIE) network. Sharing information electronically is a faster way to get health information to other organizations that may be treating you, such as hospitals, laboratories, health care providers, public health departments, health plans, and other participants. All HIE participants are required to meet rules that protect the privacy and security of your health and personal information. At any time, you can choose not to have your information electronically shared through any of our HIE networks if you advise us **in writing**.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written Authorization. Examples of disclosures requiring your authorization include disclosures to your partner, your spouse, your children and your legal counsel.



We also will not use or disclose your health information for the following purposes without your specific, written Authorization:

- **For our marketing purposes.** This does not include face-to-face communication about products or services that may be of benefit to you and about prescriptions you are taking.
- **For the purpose of selling your health information.**
- **Any disclosure of your psychotherapy notes.** These are the notes that your behavioral health provider maintains that record your conversations with your provider or group counseling session. These notes are not stored with your medical record.

If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, in **writing**, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

In some instances, we may need specific, written authorization form you in order to disclose certain types of specially-protected information such as HIV, substance abuse, mental health, and genetic testing information for purposes such as treatment, payment and healthcare operations.

USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your Protected Health Information that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

We may disclose your Protected Health Information to disaster relief organizations that seek your Protected Health Information to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request to the Compliance Officer in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. A modified request may include requesting a summary of your medical record.

If you request to view a copy of your health information, we will not charge you for inspecting your health information. If you wish to inspect your health information, please submit your request in writing to our Compliance Officer. You have the right to request a copy of your health information in electronic form if we store your health information electronically.



We may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied copies of or access to, health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

- **Right to Amend.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information was created and kept by *‘Ekahi Wellness*.

To request an amendment, complete and submit a medical record amendment/correction form to the Compliance Officer.

We may deny your request for an amendment if your request is not in writing or does not include a reason to support the request. In addition, we may deny or partially deny your request if you ask us to amend information that:

- We did not create, unless the person or entity that created the information is no longer available to make the amendment
- Is not part of the health information that we keep
- You would not be permitted to inspect and copy
- Is accurate and complete

If we deny or partially deny your request for amendment, you have the right to submit a rebuttal and request the rebuttal be made a part of your medical record. Your rebuttal needs to be three pages in length or less and we have the right to file a rebuttal responding to yours in your medical records. You also have the right to request that all documents associated with the amendment request (including rebuttal) be transmitted to any other party any time that portion of the medical record is disclosed.

- **Right to an Accounting of Disclosures.** You have the right to request an “accounting of disclosures.” This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, when specifically authorized by you and a limited number of special circumstances involving national security, correctional institutions and law enforcement. To obtain this list, you must submit your request in writing to the Compliance Officer. It must state a time period, which may not be longer than 6 (six) years. Your request should indicate in what form you want the list (for example, on paper or electronically). The first list you request within a 12 (twelve)-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also



have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment or we are required by law to use or disclose the information.

We are required to agree to your request if you pay for the treatment, services, supplies and prescriptions “out of pocket” and you request the information not be communicated to your health plan for payment or health care operations purposes. There may be instances where we are required to release this information if required by law.

To request restrictions, you may complete and submit the Request for Restriction on Use/Disclosure of Medical Information to our Compliance Officer.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you may complete and submit the Request for Restriction On Use/Disclosure of Medical Information and/or Confidential Communication to our Compliance Officer.

We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. You may also find a copy of this Notice on our website. To obtain such a paper copy, contact the receptionist.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post the current notice at our location(s) with its effective date on the first page. You are entitled to a copy of the notice currently in effect.

We will inform you of any significant changes to this Notice. This may be through our newsletter, a sign prominently posted at our location(s), a notice posted on our website or other means of communication.

BREACH OF HEALTH INFORMATION



We will inform you if there is a breach of your unsecured health information.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services at:

Office for Civil Rights, Michael Leoz, Regional Manager, 90 7th Street, Suite 4-100, San Francisco, CA 94103

Voice Phone (800) 368-1019, FAX (415) 437-8329, TDD (800) 537-7697

To file a complaint with *'Ekahi Wellness* contact (808) 942-8108. **You will not be penalized for filing a complaint.**