WASHINGTON HEALTH SYSTEM

Washington Health System Physician Offices

Acknowledgement of Receipt of Notice of Privacy Practices

The Washington Health System Physician Offices has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access this information and exercise other rights concerning this information. You may review our current notice prior to signing this acknowledgement. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effectiveness of the change. You may obtain a revised notice by submitting a request to our office.

Consent to Treat

I,_____, give my consent to the physicians of Washington Health System to perform medical services determined to be necessary or advisable for the benefit of my health care. Washington Health System is authorized to use and disclose my protected health information for treatment, payment and health care operations purposes consistent with its Notice of Privacy Practices.

- I authorize Washington Health System to bill my insurance carrier and request such payments to be made directly to Washington Hospital or Washington Physician Group. I assign to Washington Health System all rights to insurance payments or benefits to which I may be entitled for services provided to me by Washington Health System Physician Offices. I consent to access by any Washington Health System affiliate to medical or other information related to my care to be provided to such persons as necessary for them to provide treatment or services to me.
- I understand that my information may be released if required by local, state or federal law.
- I consent to and authorize the release of my sensitive medical or other information (Behavior Health and Drug & Alcohol) to my insurance carrier (s) for billing purposes.
- I understand that any amounts not paid by my insurance are my responsibility.

Medicare/Medicaid Certification

I certify that the information given to me in applying for payment under Title XIX of the Social Security Act is correct. I authorize any holder of any protected health information about me to release to the Centers for Medicare and Medicaid or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to the physician or organization providing the services or authorize that physician or organization to submit a claim to Medicare for payment to me.

_____(initials) I acknowledge that I have received the Notice of Privacy Practices.

I give permission to the staff of Washington Health System Physician Offices to release information regarding my medical care, including my medical condition, test results, appointment dates/times to the following individuals and in the selected manner.

Name	Relationship	Telephone Number

I give permission to be contacted in the following manner: ❑ Mail ❑ Telephone ❑ Other:_____

I authorize Washington Health System Physician Offices to leave a detailed message at the following numbers:

Home: _____ Mobile:_____ Work:_____

_____	_____	_____	_____	_____/_____
Patient Printed Name	Date of Birth	Signature Authorized Representative	Relationship	Date/Time

_____	_____	_____/_____
Witness Printed Name	Witness Signature	Date/Time

FOR OFFICE USE ONLY

The above named patient/personal representative was offered the Notice of Privacy Practices.
Describe how notice was provided:

❑ Offered copy and patient/personal representative refused to accept delivery.

❑ Offered copy and patient/personal representative accepted.

_____	_____	_____/_____
Employee Printed Name	Employee Signature	Date/Time