



ID _____ Provider _____

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20700 Bond Road
North Kitsap Medical Center

(360) 697-2199
Fax (360) 779-5760

Billing Information
(360) 698-6515

Adult / Minor Consent

CONSENT TO SPEAK TO: _____

RELATIONSHIP: _____ CONTACT NUMBER: _____

RESTRICTION (specify): _____

Notice of Privacy Practices

We will not disclose your records to others unless you direct us to do so or the law authorizes or compels us to do so. Our more detailed Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and how you can access your information. **AVAILABLE UPON REQUEST.**

Authorization to be treated / Authorization to Bill

I understand that I am financially responsible for all charges not covered by my authorization or insurance. Verification of coverage and pre-authorization request is not a guarantee of payment. I acknowledge that my insurance carrier may feel the exams and/or treatment recommended are not medically necessary, or they may disagree with the final diagnosis, or I may not have obtained permission from my primary care provider for the services provided. If my insurance carrier or primary care provider fails to authorize payment for services rendered I will be financially responsible for payment in full. I authorize Kitsap OBGYN, PLLC to release any information acquired in the course of my examination or treatment to my insurance company.

PATIENT NAME (PLEASE PRINT)

PATIENT SIGNATURE

DATE

WITNESS SIGNATURE

DATE

...dedicated to Women's Health Care