Washington County Hospital
304 East Third Street
Washington, KS 66968
Phone: 785-325-2211 Fax: 785-325-3224

Family Medicine of Washington County
302 East Second Street
Washington, KS 66968
Phone: 785-510-6111 Fax: 785-325-2277

Patient Name: _____ Birth Date: _____

Authorization for Medical Treatment: Clinical personnel at Washington County Hospital and/or Family Medicine of Washington County are hereby authorized to administer any medical diagnostic or therapeutic treatment as may be deemed necessary or advisable. I have the right to consent or refuse consent to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

Disclosure of Information: I understand that my medical records and billing information are made and retained by these entities and are accessible to office personnel. Office personnel may use and disclose medical information for operations, functions and to any other physician or health care personnel involved in my continuum of care. Safeguards are in place to discourage improper access. These entities and their medical staff are authorized to disclose all or part of my medical record to any insurance carrier, worker's compensation carrier or self-insured employer group liable for any part of the practice's charges and to any health care provider who is or may become involved with my care. Kansas law requires that these entities advise you that this information authorized for disclosure may contain drug/alcohol information, mental health information and information regarding communicable or venereal diseases, including but not limited: to hepatitis, syphilis, gonorrhea, HIV and AIDS. By signing this agreement, you are consenting to such disclosures.

Assignment of Insurance Benefits: I agree that provider/physician benefits otherwise payable to the insured are to be made payable to the provider/physician responsible for my care. Any payment received for this period may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits. Refusal to authorize assignment of benefits will require payment in full by cash, check or credit card at the time of service.

Precertification Policy: I understand that these providers will assist with insurance precertification requirements, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

Financial Responsibility: As consideration for the services provided, I (patient or responsible party) guarantee payment for any amount due for such services provided by this provider/physician.

I authorize confidential medical messages to be left on voicemail/answering machines at the following numbers:

Home # _____ Work # _____

Cell # _____ Other # _____ None _____

Release of Protected Health Information: Information regarding appointments and billing inquiries may be released to the following:

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

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Acknowledgement of Notice of Privacy Practices: A complete description of how your medical information will be used and disclosed by this practice is in our NOTICE OF PRIVACY PRACTICES which you have been offered. A copy is posted in this office.

_____ I have ***received*** a copy of the Notice of Privacy Practices
_____ I have ***declined*** a copy of the Notice of Privacy Practices

Acknowledgement of Payment Policy: A complete description of your financial responsibility is in our Payment Policy, which you have received.

_____ I have read and understand the Payment Policy and agree to abide by its guidelines.

Certification: I hereby certify that I have read each of the above statements, have had each item explained to my satisfaction and have been offered a copy of this Patient Agreement. I further certify that I am the patient or duly authorized by the patient to accept the terms of this Patient Agreement that shall be valid for three (3) years from the date of my signature, unless otherwise stated. A photo copy of this document shall have the same effect as the original.

Signature: _____ Date: _____

Printed Name: _____ Relationship: _____

THIS CERTIFICATION SHALL BE VALID FOR ALL ***MINOR CHILDREN*** IN THE SAME HOUSEHOLD LISTED BELOW

Name: _____ Birthdate: _____ Sex: Male Female

Name: _____ Birthdate: _____ Sex: Male Female

Name: _____ Birthdate: _____ Sex: Male Female

Name: _____ Birthdate: _____ Sex: Male Female

Name: _____ Birthdate: _____ Sex: Male Female

Name: _____ Birthdate: _____ Sex: Male Female