North Spokane Women's Health

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

We keep a record of the health care services we provided to you. You may ask to see and have a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting
North Spokane Women's Health PS.

Our *Notice of Privacy Practices* describes in more detail how your health information may be used and disclosed, and how you can access your information.

INSURANCE/HIPAA

I understand that insurance contracts are between insurance companies and the insured. Payment for our services remains my responsibility. **North Spokane Women's Health** (NSWH) will bill my insurance company *if I present a current insurance card the day of the service.* If I do not have any insurance card on the day of service it becomes my responsibility to bill my insurance and to pay for such services. If a financial contract is needed, NSWH, reserves the right to obtain a credit report for financial status.

I assume responsibility for items or services that are not covered by my insurance. All co-pays, co-insurance, deductibles and non covered services by my insurance are to be paid the day of the service or before a procedure. Please assign insurance benefits to the attending physician. In the event that my insurance company requests copies of my medical records, I hereby give consent for their release.

☐ I acknowledge receipt of the *Notice of Privacy Practices*
☐ I give NSWH permission to call and leave a message and give permission to confirm my medical appointments.
☐ I give NSWH permission to leave a text message and give permission to confirm my medical appointments.
☐ I give NSWH permission to view my prescription history from external sources.
☐ I give NSWH RESEARCH permission to contact me for research studies. You may also share information with medical researchers preparing to conduct a research project.

_____ _____
PATIENT OR LEGALLY AUTHORIZED INDIVIDUAL 'S SIGNATURE DATE

_____ _____
PRINTED NAME IF SIGNED ON BEHALF OF THE PATIENT RELATIONSHIP

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