UROLOGY NORTHWEST, PS

UROLOGY NORTHWEST SURGERY CENTER | INTEGRITY MEDICAL RESEARCH

6005 244TH ST SW | MOUNTLAKE TERRACE | WA | 98043

ACKNOWLEDGEMENT OF RECEIPT

Patient Name: ____ **Date of Birth:** _________________________

I acknowledge that a full copy of Urology Northwest's privacy policy (HIPAA), financial policy and clinical guidelines are available upon request at any time.

- ✓ **NOTICE OF PRIVACY PRACTICES (HIPAA)**
- ✓ **FINANCIAL POLICY / CLINICAL GUIDELINES**

The **NOTICE OF PRIVACY PRACTICES** describes how my health information may be used or disclosed. The section "Your Health Information Rights" explains the treatment I can expect from the facility and physician. I understand it is my responsibility to read the policy or ask that it be read to me. I am aware that the policy may be revised at any time and I can receive the most current version of the policy by calling 425-275-5555 or by requesting a copy at the office.

X____

(Patient Signature) (Date Signed)

PERMISSION TO BE CONTACTED:
I give Urology Northwest/Urology Northwest Surgery Center/ Integrity Medical Research permission to contact me by phone, e-mail, or mail to inform me of upcoming educational events that may benefit me or about research studies being conducted that may benefit me. I may also be contacted by my preferred method for appointment reminders. This option excludes sending any medically related information regarding your treatment via text or email.

YES NO Preferred method of contact: ☐ Phone ☐ Text ☐ Email: ________________________

PERMISSION TO LEAVE A MESSAGE:
I give Urology Northwest/Urology Northwest Surgery Center/Integrity Medical Research permission to leave a personal message on my answering machine regarding any or all ongoing medical conditions.

YES NO Phone: _____________________________ HOME / WORK / CELL (Circle One)

I give Urology Northwest/Urology Northwest Surgery Center/Integrity Medical Research permission to speak with another person (spouse, significant other, family member(s) about your medical condition(s) or finances.

YES NO **If YES, please provide name/relationship & contact # below (Please print):

____

Name Relationship Contact Number

FINANCIAL POLICY & CLINICAL GUIDELINES document provides information as to my financial rights & responsibilities as they relate to services provided to me Urology Northwest/Urology Northwest Surgery Center/Integrity Medical Research.

X____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I authorize the release of medical or other information necessary to process health insurance claims or as necessary for my course of treatment. I understand that sensitive material from my medical history may be included.

X____

AUTHORIZE TO PAY BENEFITS TO PHYSICIAN: I hereby assign to Urology Northwest, PS all payments for medical services rendered to myself or to my dependents. I understand that I have financial responsibility for any amount not covered by my health insurance.

X____