CONSENT AND DISCLOSURE

I understand and agree that all communication between my physician and me is held in confidence unless:

1. I authorize release of information with my signature.
2. My physician is ordered by a court to release information.
3. Child or elder abuse is reasonably suspected.
4. My physician believes that there is imminent risk of my harming an identifiable third party or myself.

I understand that in the latter two cases the physician is required by law to inform legal authorities and/or potential victims.

_____ _____
Initials Date

PATIENT CONSENT & RELEASE

I authorize treatment and agree to pay all fees associated with such treatment. I authorize my insurance benefits to be paid directly to Angela Heithaus MD. I authorize the release of any information required to process my claim the to the necessary insurance companies, third party payers, and/or other physicians or health entities required to participate in my care. I agree that I am financially responsible for all services provided.

_____ _____
Initials Date

FINANCIAL POLICY

Our office is committed to providing quality and cost-effective healthcare to our patients. Insurance reimbursement is a contract between you and your insurance company. It is essential that you understand which services and procedures are covered by your insurance plan and obtain any necessary authorizations and referrals prior to your appointment. It is your responsibility to understand the limits and restrictions affecting coverage of services you receive. As a courtesy to you we will file selected primary and secondary claims for you. We will require a current copy of your insurance card in order to do this and we will need to be informed of any changes in insurance status. You will be responsible for all co-pay, deductibles, and coinsurance amounts not covered by your insurance policy along with the entire amount of any non-covered services. Patient who do not have insurance (or proof of coverage) or who choose to pay for covered services are expected to pay in full at the time of the service. For your convenience we will accept cash, personal check, Visa and MasterCard. If your personal check is returned by the bank due to insufficient funds, a fee will be changed. Fees will also be assessed for failure to keep scheduled appointments, or failure to cancel with at least 24-hour notice. We realize that healthcare is sometimes unplanned event, so we will attempt to accommodate your needs as circumstances require. Please call our office at 206 428 2080 with any questions you may have regarding our financial policy and procedures.

_____ _____
Initials Date