

Patient's Name: _____ DOB: _____

AUTHORIZATION AND CONSENT

Authorization and Consent

- I consent that I am being seen by a provider of Community Health of Central Washington for examination, diagnosis and /or treatment of my health, medical or dental condition.
- I give consent and authorize my provider/clinician(s) or his or her designees to order and/or perform all exams, tests, procedures and any other care deemed necessary or advisable for the diagnosis and treatment of my health, medical or dental condition.
- This consent is valid for each visit from a Community Health of Central Washington provider unless revoked by me in writing.
- I authorize and request my insurance company to pay directly to Community Health of Central Washington benefits otherwise payable to me.
- I understand that my medical and/or dental insurance carrier may pay less than the actual bill for services and that I am financially responsible for all charges for services rendered to me or my dependents, including the balance remaining after payment of possible insurance benefits, deductibles and applicable co-payments.
- I have received the Notice of Privacy Practices:

Signature

Patient/Healthcare Decision Maker: _____

Date: _____

Facility where patient currently resides: _____