SANDPOINT SURGICAL ASSOCIATES
502 North Second Avenue Suite 3 Sandpoint, ID 83864-1558 (208)263-1421

Patient Consent for Use and Disclosure of Protected Health Information

In signing this form, you consent to the use and disclosure of your protected health information by ***Sandpoint Surgical Associates***, our staff, and our business associates strictly for the purpose of treatment, payment and health care operations.

You acknowledge you have had an opportunity to review our ***Notice of Privacy Practices*** prior to signing this consent. We encourage you to review our ***Notice of Privacy Practice***s carefully. It provides more detail on how we may use and disclose your information. The ***Notice of Privacy Practices*** may change. A current copy may be requested when you are being seen as a patient or by contacting our office manager at 263-1421.

You may request that we restrict how we use and disclose your protected health information for the purposes mentioned above. If you would like to request a restriction, please do so in writing. However, we reserve the right to deny your request. If we grant your request, we are bound by the terms of the agreement.

You may also revoke this consent in writing; however, information on any treatment / service provided using this or prior consents may still be used or disclosed for purposes of treatment, payment, or health care operations. Refer to the ***Notice of Privacy Practices*** for further information.

By signing this form, I grant my consent to the medical practice use and disclose my protected health information for the purposes of treatment, payment and health care operations.

_____ _____

Signature of Patient or Surrogate Decision Maker: **Date:**

Relationship to Patient/ Legal authority *(if applicable)*: _____

For Practice use only

Failure to obtain consent Check the appropriate reason:

☐ **Indirect Treatment Relationship** ☐ **Emergency treatment**
☐ **Substantial Communication Barrier** ☐ **Refusal to Sign** ☐ **Other**

Description:

_____ _____

Practice Signature **Date**

_____ _____

Witness **Date**

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502 NORTH SECOND AVE Suite 3 SANDPOINT, ID 83864-1558
PHONE (208) 263-1421 FAX (208) 263-4430

AUTHORIZATION FOR TREATMENT - RELEASE OF INFORMATION
FINANCIAL AGREEMENT - ASSIGNMENT OF BENEFITS

I, the undersigned, knowing the patient is suffering from a condition requiring health care, diagnosis, and medical treatment, hereby do voluntarily agree to such diagnostic procedure and health care service which may be administered to or performed on the patient under the instruction of ***Nathan C. Kanning, MD, FACS, Chase C. Williams, MD*** or their assistants or assignees.

I assume full financial responsibility for all debts incurred in any treatment and follow-up care received.

I authorize release of any medical information needed by the patient's insurance company to process this claim. I also request payment of medical benefits, as described on the insurance claim form be made directly to ***Sandpoint Surgical Associates***.

Signature _____
Date _____ Relationship to Patient _____

MEDICARE ASSIGNMENT

I request that payment of authorized Medicare benefits be made on my behalf to ***Sandpoint Surgical Associates*** for any services furnished to me by Dr. Nathan Kanning, Dr. Chase Williams, or their assistants or assignees. I authorize any holder of medical information about me to release to the Centers of Medicare and Medicaid Services, formerly the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable for related services.

Signature _____
Date _____ Relationship to Patient _____

PATIENT'S ASSIGNMENT OF AUTHORIZATION

NAME OF BENEFICIARY _____
HICN (medicare number) _____
MEDIGAP INSURANCE _____ POLICY NUMBER _____

I request that payment of authorized Medigap benefits be made on my behalf to ***Sandpoint Surgical Associates*** for any services furnished to me by Dr. Nathan Kanning, Dr. Chase Williams, or their assistants or assignees. I authorize any holder of medical information about me to release to (name of Medigap Insurer) _____ any information needed to determine these benefits.

Signature _____
Date _____ Relationship to Patient _____