Patient Name ____

I give My Permission to Leave Messages at my:

Residence	Y	N	(____)________________________
On My Cell Phone	Y	N	(____)________________________
Work	Y	N	(____)________________________
Email	Y	N	______________________________

Authorization to Release Health Care Information to:

Please Initial and Print Full Name

____ Spouse ______________________________________

____ Parent ______________________________________

____ Child/ Children ________________________________

____ Legal Guardian ________________________________

____ Personal Representative ___________________________

____ Other_______________________________________

I understand that my express consent is required to release any health care information relating to testing, diagnosis and/or treatment for HIV (AIDS virus), Sexually transmitted diseases, psychiatric disorder/mental health and/or drug and alcohol use, and billing. You are specifically authorized to release all such information to those listed above. This form is valid for one year from date signed.

Patient Signature ______________________________ Date ________________

Insurance Coverage Waiver

I understand that I am responsible for charges not covered by my insurances company (Insurance Company Name)__________________(Primary) and/or (Insurance Company Name)__________________(Secondary). I wish to obtain medical services from Cascade Family Medicine, P. S. If it is determined that I am not eligible for coverage I understand that I am responsible for payment for all services provided.

I understand that Cascade Family Medicine, P.S., charges a fee for telephone visits, long distance calls for prescription refills, Prior authorization forms for prescriptions, and any additional forms requiring a physician signature. This agreement is providing me notification prior to services provided.

Patient Signature ______________________________ Date _________________