CYNTHIA TAYLOR, MD, MPH, FAAFP
FAMILY PRACTICE
14212 Ambaum Blvd. SW, Suite 106
Burien, WA 98166
(206)244-5520

Consents and Acknowledgements

CONSENT TO MEDICAL CARE:

The undersigned consents to any laboratory, imaging, anesthetic, medical or surgical services rendered to the patient by Dr. Taylor or under her supervision or instruction. This includes observation for the purposes of education of medical students or other health care trainees whose presence is deemed appropriate by Dr. Taylor.

It is understood that no guarantee or assurance has been made as to the results of treatment.

RELEASE OF PATIENT INFORMATION:

The undersigned consents that Dr. Taylor may release information related to the patient's medical treatment to the guarantor's insurance company or another third party payer, in order to secure payment for services rendered. This may include HIV or sexually transmitted disease testing or treatment, or records of psychiatric, alcohol or drug treatment.

ASSIGNMENT OF INSURANCE BENEFITS:

Any medical insurance benefits are assigned to Dr. Taylor for application to the patient's bill, and Dr. Taylor is authorized to bill and collect from Medicare and other insurances directly. The patient may be responsible for 100% of charges not covered.

THE UNDERSIGNED CERTIFIES:

That I have read the forgoing and am the patient or duly authorized as the patient's legal representative, and

That I have received a copy of the Privacy Notice.

PERMISSION TO TREAT MINORS:

_____I give Dr. Taylor or her designee permission to treat _____
for any medical or surgical problems which may arise during my absence

X_____ _____/_____/_____
Signature Date

_____Patient or _____Representative (Relationship _____)

CYNTHIA TAYLOR, MD, FAMILY PRACTICE

PRIVACY NOTICE

Dear Patients,

The law requires us to keep your medical information private. We must also notify you of our legal duties and privacy practices, and follow these policies:

SHARING INFORMATION

Information about you and your health care may be disclosed for the following uses:

1.TREATMENT:

a.We may share information with other health care professionals assisting in your care, such as doctors, nurses, Home Health providers, pharmacists, physical therapists, or providers of ancillary services like lab and X-rays .

b.A friend or family member helping with your care, with your permission, or if you are unable to give permission, if we judge it in your best interest

2.PAYMENT:

We may share information with insurance companies and others to bill and collect payment on your account, and to obtain eligibility and precertification for medical tests and procedures.

3.HEALTHCARE OPERATIONS:

We may disclose information about you when it is necessary for quality improvement, training of medical personnel, audits for licensure or compliance, and to provide you with information

4.PROTECTION:

In case of a medical emergency, or to protect someone in cases of abuse or neglect

5.LEGAL:

For legal proceedings, or when otherwise required by law.

YOUR RIGHTS

1.ACCESS:

You have the right to view and get copies of your own records.

2.RESTRICTION:

You can request restrictions on who has access to your records

3.CONFIDENTIALITY:

You have the right to receive communication about your care in a confidential manner

4.AMENDMENTS:

You can request amendments to your record if you disagree with its content, although we have the right to deny your rquest. In that case, we will provide a written explanation, to which you may respond with a statement of disagreement which can be added to the information you want changed

5.DISCLOSURE ACCOUNTING:

You have the right to know of anyone to whom we disclose information

WE RESERVE THE RIGHT TO CHANGE OUR PRIVACY PRACTICES AT ANY TIME, IF NEEDED

Your signature acknowledges that you have reviewed this information:

_____ _____/____/_____

Name Date