CONSENT FORM

CONSENT TO TREAT

I am voluntarily seeking medical care and treatment from Selkirk Endocrinology and give permission to the medical staff of Selkirk Endocrinology to examine me, make diagnoses, and provide treatment to me in accordance with the information, explanations, and recommendations they provide me.

Patient Signature: _____ Date: _____

Print Name: _____

CONSENT TO BILL

I authorize Selkirk Endocrinology to bill my health insurance company for medical services provided.

I authorize Selkirk Endocrinology to release my records to my health insurance company in accordance with privacy policy.

I understand that my health insurance company may not cover all charges deemed medically necessary by Selkirk Endocrinology.

I understand that I am responsible for any part of the charges that are not covered by my insurance and I will be billed directly for those services.

I am aware that Selkirk Endocrinology follows HIPPA privacy rules regarding my health information. I have been offered a copy of the policy to review.

Patient Signature: _____ Date: _____

Print Name: _____