1601 116th Ave NE Ste 111
Bellevue, WA 98004

P: 425-647-1314
F: 425-458-3102

Patient Name: ___________________________________ Date:___________________

(THE ASSIGNMENT AND CONSENT WILL BE SIGNED AT THE FIRST OFFICE VISIT)

ASSIGNMENT OF INSURANCE BENEFITS

I, the undersigned, have insurance coverage with __________________________________
And assign directly to Eastside Primary Care and Wellness, Erik Suh MD. PS. All medical benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Eastside Primary Care and Wellness, Erik Suh MD. PS. to release all information necessary, to secure the payment of benefits. I give permission to Eastside Primary Care and Wellness, Erik Suh MD. PS. to release information to my other health care providers. I authorize the use of this signature on all my insurance submissions.
X____ Date: ________________________
Signature of insured/Guardian

CONSENT TO TREATMENT

It is our philosophy that patients should have full disclosure when receiving any type of health care. We therefore ask that you read and sign the following consent. We also fee that any individual should request the same full disclosure from any other health care provider and their proposed treatment plan. Educated choices are the only choices.

I understand that as a patient of Eastside Primary Care and Wellness, Erik Suh MD. PS., I will receive an initial evaluation, and thorough discussion of treatment options. The goal of the initial evaluation process is to determine the vest course of treatment for me. I understand that typically treatment is provided over the course of several weeks to months.

I understand that all information shared with the healthcare providers is confidential and that no information will be released without my consent. During the course of treatment, it may be necessary for my providers to communicate with other healthcare practitioners. I understand that consent to release information is given through written authorization. Verbal consent for release of limited and essential information may be necessary in special circumstances.

I understand that while treatment may provide significant benefits, it may also pose risks. Short of overt negligence, I agree to hold the healthcare providers of Eastside Primary Care and Wellness, Erik Suh MD. PS. harmless in case of undesirable effects of undertaking or discontinuing treatment. I also understand that I may stop treatment at any time.

Please not: If applicable, co pays are due at each visit. I also understand that unless other arrangements have been made ahead of time, payment in full is due at the end of service each day.
It is your right to have a chaperon in the room during your exam. We will provide someone upon request.

If I have any questions regarding this consent form or about the services offered, I am encouraged to discuss them with the treating healthcare provider. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by the individual healthcare providers. I understand that I have the right to suspend any treatment at any time but that if this suspension of treatment is against medical advice that the consequences of my decision are my own responsibility.

X____ Date:________________________
Signature of insured/Guardian