Patient Name:_____ Home Phone:_____

Cell Phone:_____ Email:_____

Parent or Guardian of Minor:_____
Contact Number: _____ □ Cell □ Home

Drs. North & Watson's Notice of Privacy Practices (HIPAA)

- I authorize Drs. North & Watson to release any medical information to other providers who are involved in my treatment.
- I acknowledge that I have been given the opportunity to read and/or receive Drs. North & Watson's Notice of Privacy Practices.
- This authorization and assignment will remain in effect until revoked by me in writing.

- The following person(s) have my permission to discuss health and financial information on my behalf. (Optional)
  Please list:

x_____ _____
Signature of patient or guardian of minor Today's Date

Drs. North & Watson's Financial Policies

- I understand that I am financially responsible for payments of any services provided by Drs. North & Watson, including services not covered by my insurance, as well as co-pays, deductibles and coinsurance.
- Co-pays are expected on the day of service. A finance charge is added to every delinquent statement and $18 to all returned checks.
- I request that payment of authorized insurance benefits, including Medicare, be made to Drs. North & Watson for services furnished to me by any provider employed by this clinic.

x_____ _____
Signature of patient or guardian of minor Today's Date

I have chosen the Private-Pay option and DECLINE insurance submission.
Payment is expected on the date of service.

x_____ _____
Signature of patient or guardian of minor Today's Date