DAVID B. MINOR, M.D.

Name: _____ Date: _____

Street Address: _____ City / State: _____

Zip Code: _____ Date of Birth: _____ Birth Gender: _____

Phone Number (home): _____ Phone Number (mobile): _____

Email Address: _____

Emergency Contact: _____ Phone:_____

Spouse Name: _____ Phone:_____

Caretaker Name: _____ Phone:_____

Patient Policies and Notices

Insurance Processing Notice

David B. Minor, MD PC may release any information necessary to process my insurance claims.

_____

Signed (Patient/Responsible Party) Date

Financial Policy

I have read or been offered a copy of the financial policies for David B. Minor, MD PC and understand them as outlined.

_____

Signed (Patient/Responsible Party) Date

Notice of Privacy Practices

I have read or been offered a copy of the notice of privacy practices for David B. Minor, MD PC and accept the terms.

_____

Signed (Patient/Responsible Party) Date

Consent to the Use and Disclosure of Health Information for Treatment, Payment or Healthcare.

Disclosure: Information may be released to the following individuals/organizations.

_____

Restrictions: I request the following restrictions to the use and/or disclosure of my health information.

_____

_____

Signed (Patient/Responsible Party) Date