NORTHERN
Family Medicine
a department of Northern Regional Hospital

1016 S South Street
Mount Airy, NC 27030
336-783-8900

Patients Legal Name _____
Last **First** **Middle**

Date of Birth_____Sex: ☐ F ☐ M Race:_____Ethnicity: _____SS#_____

Email address_____I Decline to give an email address_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

I hereby acknowledge receipt of the **NOTICE OF PRIVACY PRACTICES** , **PATIENTS / PARENTS / GUARDIANS RESPONSIBILITY and NO SHOW POLICY** notices given to me by **Northern Medical Group Family Medicine .**

I give permission to Northern Family Medicine to file any claims on my behalf to my insurance company for billing purposes. I also give permission to Northern Family Medicine to send any medical records requested by my insurance company to process these claims.

I understand that I am responsible for any charges in full at time of visit if I do not have insurance. I am responsible to pay the co pay or deductibles at the time of my visit. I further understand that I am responsible for any charges that are NOT a covered service with my insurance plan. I understand that an insurance card presented to Northern Family Medicine not a guarantee of payment. I understand that if I am self-pay or pay a percentage that the amount I am given is an estimate and may billed for the remaining.

I give Northern Family Medicine permission to treat and to send information to my referring physician and referred physician if deemed necessary by my physician.

I give the names listed below permission to discuss my treatment, pick up prescriptions and pick up any forms.

_____

I understand that I may revoke this authorization at any time by presenting a request for revocation in writing to a Health Information Department of Northern Family Medicine; however, a revocation will not reverse any action already taken in reliance upon this Authorization.
I also understand that the information disclosed pursuant to the authorization may include information concerning patient's mental health, use or treatment concerning drugs and/or alcohol, HIV/AIDS and/or other communicable diseases and/or genetic testing results.

I give Northern Family Medicine permission to retrieve my medication history through the Sure scripts E- Prescription Network.

I understand that I have the right to request restrictions concerning the use of my information. Below are those restrictions:

_____

_____

Patient or Guardian Signature: _____ Date/Time: _____