Name:
Shared ID: DOB:
Date:

Patient Financial Policy

_____ **(Initials)**

I have received a copy of the North Alabama Bone & Joint Clinic's Patient Financial Policy and agree to its terms.

HIPAA

_____ **(Initials)**

I hereby authorize and give my consent to North Alabama Bone & Joint Clinic, P.C. to leave messages on my voicemail or answering machine.

I do not authorize North Alabama Bone & Joint Clinic, P.C. to leave messages on my voicemail or answering machine.

I hereby authorize and give my consent to North Alabama Bone & Joint Clinic, P.C. to communicate any of my Protected Health Information to the following persons:

Name (*Please Print*)	**Relationship to Patient**

eRx

_____ **(Initials)**

By signing this consent form you are agreeing that North Alabama Bone & Joint Clinic may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes. I have had the chance to ask questions and all of my questions have been answered to my satisfaction.

_____ _____

Patient Signature **Date**