



Eric North, MD • P. Senna North, MD

530 Welch St • Silverton, Oregon 97381 • 503-874-6026

Agreements and Policies: Authorization and Agreements for Treatment, Emergency Care, or Out Patient Services by Dr. Eric North and/or Dr. Phoenix Senna North.

Consent to Treatment: I hereby grant consent for treatment or services to be provided by the physicians and employees, and I also certify that no guarantee or assurance has been made as to the results which may be obtained.

Consent to Treat Minor: I am the parent or legal guardian. I hereby consent to treatment or to services to be provided by the physicians and employees.

Release of Medical Information: I hereby authorize the clinic to release any medical information or charges in connection with these services to, but not limited to, an insurance carrier, workmen's compensation carrier, medical service companies, Health & Welfare Funds or the patient's or responsible party's employer.

Insurance Assignment: I hereby assign medical benefits of any type whatsoever arising out of any policy of insurance insuring the patient or any party liable for the patient's care to the clinic for application to the patient's bill.

Financial Agreement: For and in consideration of the care and treatment provided to the patient, I promise to pay the clinic all charges for services rendered to or on behalf of the patient.

Office Policies and Practices

1. We remind you that your medical insurance is a contract between you and your insurance company and does not affect your responsibility to our office for prompt payment.
2. We may furnish information to insurance companies regarding services rendered.
3. As a service to our patients, most insurance companies will be billed.
4. Minimum payment on account balances less than \$200.00 will be \$20.00
5. Minimum payment on account balances over \$200.00 will be 10% of the balance.
6. There will be a \$3.00 re-billing fee assessed if minimum payment is not made within the billing cycle.
7. Accounts past due for 60 days may be forwarded to a collection agency.
8. A \$15.00 charge will be assessed for any NSF check received as a payment on accounts.

By signing below, I acknowledge that I fully understand and agree to the policies and practices of this office. I also agree that all the information provided is true to the best of my knowledge. I also hereby authorize the payment of insurance benefits for professional services rendered to:

Print Patient Name

Witness Signature

Print Guarantor's Name (If patient is under 18) and relationship to patient

Patient/Guarantor Signature

Date

NEW PATIENT INFORMATION

Name _____
Last Name First Name Middle Initial Nickname _____

Address _____

City _____ State _____ Zip _____ Home Phone _____ Cell Phone _____

Male Female Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Email address _____

Employer _____ Occupation _____

Business Address _____

City _____ State _____ Zip _____ Business Phone _____

In case of emergency who should be notified? _____ Phone _____

Primary language that you speak _____

What ethnicity describes you best Hispanic or Latino Not Hispanic or Latino Unknown

What race describes you best African American Alaskan Native American Indian Asian Caucasian

Greek Hawaiian Hispanic Indian Pacific Islander Russian

More than one race Other _____

What pharmacy would you like to use _____

PRIMARY INSURANCE

Person Responsible for Account _____ Birthdate _____
Last Name First Name Middle Initial

Relationship to Patient _____ Social Security Number _____

Address (if different from above) _____

City _____ State _____ Zip _____ Phone _____

Employer _____ Business Address _____

City _____ State _____ Zip _____ Business Phone _____

Insurance Company _____ Office Visit Copay _____ Deductible _____

Subscriber/ID # _____ Group # _____

SECONDARY INSURANCE

Subscriber Name _____ Birthdate _____
Last Name First Name Middle Initial

Relationship to Patient _____ Social Security Number _____

Address (if different from above) _____

City _____ State _____ Zip _____ Phone _____

Employer _____ Business Address _____

City _____ State _____ Zip _____ Business Phone _____

Insurance Company _____ Office Visit Copay _____ Deductible _____

Subscriber/ID # _____ Group # _____

Consent for Disclosure of Information

Please list the family members or other persons, if any, whom we may inform about your general medical condition and diagnoses (including treatment, payment and health care operations):

I do not authorize release of my information to anyone else

The following people may have access: _____

Password to access your information: _____

Oregon law requires that we not release health information unless we are able to verify that person's identity. Thank you for providing us with a personal password to help us protect your health care information.

Print Patient Name

Print Guarantor's Name (If patient is under 18) and relationship to patient

Patient/Guarantor Signature

Date

Acknowledgement of Receipt of Notice of Privacy Practices

I have been given an opportunity to review the Notice of Privacy Practices (available for review in our office and on our website) and understand I may refuse to sign this acknowledgement. I understand that I am entitled to receive a copy of the Notice of Privacy Practices.

Print Patient Name

Print Guarantor's Name (If patient is under 18) and relationship to patient

Patient/Guarantor Signature

Date