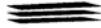


DAVID B. MINOR, M.D.



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