

**Notice of Privacy Practices: Patient Acknowledgment and Agreement**

By signing below I hereby acknowledge that I have read, and fully understand Northside Family Medicine's Notice of Privacy Practices for Protected Health Information (HIPAA Agreement) and may ask for a copy if desired. Furthermore, we agree that at the discretion of Northside Family Medicine, Northside Family Medicine may release any information necessary to any member of my household or immediate family (sons, daughters, parents, spouses) unless I notify Northside Family Medicine otherwise.

\_\_\_\_\_  
Name of Patient (please print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

PLEASE DO NOT RELEASE MY INFORMATION TO THE FOLLOWING PEOPLE \_\_\_\_\_

**Assignment of Benefits**

- 1) I understand that I am responsible for charges not covered or reimbursed by my insurance company(s). I agree that in the event of non-payment, to assume the costs of interest, collection, and legal action (if required).
- 2) I authorize my insurance carrier(s) to release information regarding my coverage to Northside Family Medicine. I also authorize agents of any hospital, treatment center, or previous physicians to furnish Northside Family Medicine copies of any records of my medical history, services, or treatments.
- 3) My right to payment for all procedures, supplies, and any other services including major medical benefits that are provided to me by Northside Family Medicine are hereby assigned to Northside Family Medicine. This assignment covers any and all benefits under Medicare, other government sponsored programs, private insurance, and any other health plans. I acknowledge this document as a legally binding assignment to collect my benefits as payment of claims for services performed by Northside Family Medicine. In the event that my insurance carrier does not accept Assignment of Benefits, or if payments are made directly to me or my representative, I will endorse such payments to Northside Family Medicine.
- 4) I understand I have a right to request and receive a Notice of Privacy Practices from Northside Family Medicine.
- 5) I hereby authorize Northside Family Medicine to inquire into my credit history if needed to obtain payment from me or confirm information that I have provided. It will only be done if I am not paying my bills as agreed upon above and will not be released to any outside agencies that are not directly involved in obtaining payment from me for services performed at Northside Family Medicine.

**By signing below I have read the above statements and accept the terms and have been provided a copy of this statement if I have requested it.**

\_\_\_\_\_  
Patient or Responsible Party Signature

\_\_\_\_\_  
Date

**Online Communications Informed Consent: Patient Acknowledgment and Agreement**

I acknowledge that I have read and fully understand the Online Communications Informed Consent form. I understand the risks associated with online communications between my physician and me. In addition, I agree to the instructions and restrictions outlined herein and that they may change without warning. I have had a chance to ask any questions that I had and to receive answers. Please notify us if you want a copy of our Online Communications Informed Consent. I realize that email that is being sent or received from Northside Family Medicine is not secure and could be read or intercepted by others. **FURTHERMORE, WHEN THE SECURE OPTION BECOMES EASIER TO USE WE MAY SEND ALL CORRESPONDENCE TO YOU VIA SECURE EMAIL.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
your email address

**Patient Guidelines: Patient Acknowledgment and Agreement**

**By signing below, I hereby acknowledge that I have read, and fully understand Northside Family Medicine's Patient Guidelines and agree to abide by the standards set therein. In addition to the instructions outlined therein, I agree to any other instructions that my physician may impose. I have had a chance to ask any questions that I had and to receive answers and have been provided a copy of the guidelines if requested.**

\_\_\_\_\_  
Patient or Guardian Signature

\_\_\_\_\_  
Date